University of Alberta

Dying in the West: Health Care Policies and Caregiving Practices in Montana and Alberta, 1880-1950

by

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Dedicated with love

to the memory of

Dorothy Mary Prosser

1932-2000

ABSTRACT

Although the politicization of care of the dying emerged in the late twentieth century, concerns about where terminal care ought to be provided and by whom have preoccupied many patients, families, physicians, and health policymakers for at least the past century. Alberta and Montana sometimes took different approaches in developing hospitals, sanatoria, and other health care programs, some of which aided the dying. However, it is clear that up until at least 1950, regional similarities were more significant than national differences when it came to care of the dying. The border did not delineate differences for the terminally ill. In Montana, federal initiatives created change, whereas provincial initiatives from the United Farmers of Alberta and the Social Credit governments, in particular, created change in Alberta. However, between 1880 and 1950 doctors and government officials dealt with similar problems and the experiences of terminal illness from patient and family perspectives were remarkably similar. Like most Canadians and Americans, Albertans and Montanans viewed care of the dying as a private family matter to be handled in the home, not a public health or medical matter requiring government support. Yet, various health care institutions faced the issue of when and how to provide terminal care to those without nearby family members. In particular, the fact that there were significantly more men than women in Montana and Alberta for most of the period examined in this study led at least a portion of the unmarried men to die in hospitals.

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PREFACE

Dealing with Dying: My Family's Story

In early February 2000, I sat with my parents in an examining room at the Cross Cancer Institute in Edmonton and listened to an oncologist tell us that my mother had only three weeks to live. Diagnosed with acute leukemia thirteen months earlier, Mom had endured over a year of chemotherapy. For the first several months of treatment, the oncologist was optimistic that he could get my mother's leukemia into remission, at least temporarily. It was not to be. Without a remission, my mother's chances of surviving five years evaporated, but continued chemotherapy treatments bought her some additional time. Unfortunately, the treatments were very debilitating and severely compromised her immune system. Over the course of a year she had twice ended up in the hospital with potentially life-threatening infections, and during her last hospital stay in January 2000, she was treated for a critically low platelet count. By that time, it had become evident that the treatments were doing more harm than good and we were not entirely surprised to learn on that February morning that the doctor had run out of treatment options. Still, we were stunned to learn that the time left to my mother could be counted in weeks.

My mother chose to die in her home, and our family chose to care for her there. She wanted to die in her own bed, surrounded by the people and things that she cared about, and she believed that our family would be more comfortable caring for her in familiar surroundings. Furthermore, she was adamant that she did not want invasive or aggressive medical intervention during her final days or hours, intervention she associated, correctly or not, with dying in hospital.[1] Although we had always hoped for a better outcome, in anticipation of the inevitable we had investigated the professional support services that we would need to care for Mom at home in Lindale, the small community in Central Alberta where my parents had resided for ten years. We had met with a knowledgeable and compassionate general practitioner in nearby Drayton Valley who had committed to making house calls if necessary. In addition, several registered nurses from Drayton Valley's regional home care nursing team had visited Mom in her home following her several hospitalizations. The nurses could visit daily, if needed, and could also arrange for practical nursing assistance as required.

Circumstances clearly prescribed which members of our family could provide informal care. My father and I acted as primary caregivers. Dad was retired, in excellent physical condition, and in complete denial about the seriousness of my mother's condition. He had chosen optimism as his coping mechanism throughout Mom's illness, and although my mother, my siblings and I were concerned about his denial, his acting as if nothing was amiss helped to inspire the environment of normality that prevailed in my parents' home during the final weeks of my mother's life. His inner pain well hidden, Dad continued in his usual capacity as chief cook and errand-runner and took on the additional onerous task of answering the ever-increasing number of telephone calls that we received from immediate family members and concerned friends and relatives each evening.

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[1] Indeed, with today's advances in medical technology, aggressive medical care can sometimes be delivered as easily in the home as in the hospital. On the topic of medical technology in the home, see John D. Arras, *Bringing the Hospital Home: Ethical and Social Implications of High-Tech Home Care* (Baltimore: Johns Hopkins University Press, 1995).

As a doctoral student with a husband and nearly grown children, I was the only one of my parents' four children who had the freedom and ability to stay in Lindale and dedicate the time and energy required to care for my mother. My eldest brother lived in Ontario. Another brother lived the same distance from my parents as I did, about an hour and a half away, but worked long hours and traveled often in his position with a large telecommunications company. My younger sister, a single parent to two young children, worked full-time and lived five hours away in Peace River, Alberta. Aside from being a practical candidate for caregiver, I was deeply committed to taking on the role. Since I had been able to attend all of Mom's medical appointments in the previous months, I was very familiar with her experience with leukemia. I had monitored and administered her medications, and I had spent hours in my university's health sciences library, researching her illness and learning how to anticipate its fatal progression. I had already assumed the role of "nurse" to my mother throughout her travails with the toxic treatments, and as difficult as it was emotionally, given our very close relationship, I was confident that I could see her through the terminal stage of her illness.

My mother lived for seven weeks, not three. Medical science had proved unable to cure her leukemia, but a focus on palliative care created an environment of tranquil comfort and even healing. Indeed, as we found, healing is possible even when curing is not.[2] In the short time available to us, our family found ways to mend emotionally and spiritually, and even to nurture family relationships. Although she was expected to die shortly, my mother's physical condition actually improved for several weeks. Within one week of stopping chemotherapy, Mom claimed that she felt better than she had for months. Although we continued to monitor for fever, and the general practitioner prescribed a new regimen of drugs to alleviate pain and other symptoms, with each passing day, medical concerns receded into the background of our lives. The home care nurse visited briefly once a week, and then came daily for the last three days. Fortunately and quite fortuitously, the nurse was present when my mother passed away, which greatly helped my father, my sister, and me, both practically and psychologically. The doctor visited only twice in the seven weeks, once two days before Mom died, and then again within hours after she died, as required by law.

Even though my mother was dying, living was at the forefront of each day of those final seven weeks. She was able to preserve and engage in the daily rituals and rhythms of her life. We watched all of Mom's favorite old films, enjoyed her favorite foods, visited with close family friends and relatives. We reminisced, laughed a lot, and cried a little. My sister made frequent trips, and was there for the few, final days when Mom required more intensive nursing care. When my mother died one early afternoon in late April, we were grateful for the time that we had shared at the end. Eventually, our grief was lessened considerably by the knowledge that she had died as she wished.

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[2] There is a difference between healing the spirit and healing the body. Joan Furman and David McNabb, *The Dying Time: Practical Wisdom for the Dying and Their Caregivers* (New York: Bell Tower, 1997), xvi.

However, just as David J. Roy claims, we did learn that "dying at home is by itself no guarantee of dying with dignity."[3] My mother's final hours were not peaceful, nor particularly dignified. Dying is often difficult and traumatic, and one wonders if the image of death's taking place after a final smile is not merely a myth, a hope.

When polled today, over eighty percent of North Americans state that if they were diagnosed with a terminal illness, and if they could choose, they would prefer to die at home.[4] Paradoxically, the percentage of people actually dying at home is about twenty percent or less.[5] The reality is that where terminally ill people die is prescribed more by circumstance than by choice. Caregivers are an important part of the context that shapes that choice. Our family was very fortunate. My mother's choice to die at home coincided with my family's choice and ability to care for her at home. It was the right decision for us, under our circumstances. Had things been different it might not have been possible. For instance, although my mother's condition deteriorated rapidly in her last few days, she did not spend months confined to her bed and she did not require intensive physical care over an extended period of time. She did not experience the severe pain and other complications often associated with cancer deaths. Therefore, the physical "burden" of caregiving for our family was minimal. We were also fortunate to have access to nursing and physician care in the home. Although we did not require those services to any great degree, just knowing that assistance was but a phone call away comforted us. Ironically, it seemed that living in a small community and a rural region of the province meant that my parents could access home care services more easily than if they had been living in a large city.

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[3] David J. Roy, "Home Care: Images and Reflections," *Journal of Palliative Care* 14, no. 3 (1998): 5.

[4] Eric Shackleton, "Bedside Manners," *Toronto Sun*, 26 June 2003, p. 67. The percentage of North Americans surveyed who express a desire to die at home and not in a hospital is approximately the same as it was over two decades ago. Virginia H. Hine, "Dying at Home: Can Families Cope?" *Omega* 10, no. 2 (1979): 175.

[5] Marilyn J. Field and Christine K. Cassel, eds., *Approaching Death: Improving Care at the End of Life* (Washington: National Academy Press, 1997), 45; Donna M. Wilson et al., "Location of Death in Canada: A Comparison of 20th-Century Hospital and Nonhospital Locations of Death and Corresponding Population Trends," *Evaluation and the Health Professions* 24, no. 4 (December 2001): 390.

Not everybody chooses to die at home, and home is by no means the best choice for everybody. Other sites of care, such as hospices or palliative care wards, whose express purpose is to care for the dying, can provide a warm and comfortable setting for end-of-life care. In some cases, such as when people require intensive and constant physical care, both patient and family are more comfortable with the patient receiving care from professionals outside of the home.

Indeed, not all families are as fortunate as ours in being able to provide home care if the dying person expresses a desire to die at home. Families vary widely in both needs and resources. Some terminal patients do not have a home within which care can be delivered, or live too great a distance from necessary medical support. In some cases, the nature and extent of medical care required to keep the patient comfortable is simply too complicated to be delivered at home. In other instances, patients may have no family members willing or able to provide care. Family relationships are often fragile, and families sometimes find themselves unable to sustain the additional stresses of terminal illness and the financial worries, competing demands and fatigue that often accompany caregiving. Unfortunately, in today's society, idealized assumptions about dying at home have resulted in some caregivers being pressured to provide home care to the dying.[6] Furthermore, a family approach to end-of-life care leaves out people who are without family.[7]

My family's caregiving experience was not new or unique, but part of a long tradition of care of the dying. As our experience suggests, family and community resources, perhaps more than patient choice, determine where dying will take place and who will provide care. This historical study attempts to understand what constrained and what facilitated the options of dying people and family caregivers in the past.

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[6] Kelli Isabel Stajduhar, "The Idealization of Dying at Home: The Social Context of Home-Based Palliative Caregiving" (PhD Dissertation, University of British Columbia, 2001), ii.

[7] Nancy Guberman, "Designing Home and Community Care for the Future: Who Needs to Care?"in Karen R. Grant et al., *Caring For/Caring About: Women, Home Care, and Unpaid Caregiving* (Aurora, Ont.: Garamond Press, 2004), 81.

INTRODUCTION

Pamelia and the Fergus Family Story

In the fall of 1886, 64-year-old Pamelia Fergus of Fort Maginnis, Montana, began to experience "shooting pains" in the right side of her body and noticed that her right breast was swelling and hardening in places.[1] Although her symptoms were worrisome, consulting a physician, in person or by mail, was a difficult task. Pamelia, her husband James, and their adult son Andrew lived on a large, very successful, but isolated sheep and cattle ranch located in the geographical center of the Montana territory, 200 miles east of Helena, the nearest city of any size and significance. A journey from the ranch just to the nearest railroad station could take five days by horse and buggy, and the mail traveled at the same speed. The couple did not often travel to Helena, although Mary Agnes and Luella, two of the couple's three grown daughters, lived there with their families. The youngest Fergus daughter, Lillie, lived with her husband and small children in Oregon.

Far from medical help or advice, ranchers and farmers such as the members of the Fergus family found their own ways of dealing with health matters on the "frontier," often resorting to self-diagnosis and self-treatment. Initially, Pamelia drew upon her own instincts. Believing that the cold weather of autumn had caused her pain, she diagnosed rheumatism. Several months later, a troubled James examined Pamelia's breast closely for the first time. His examination, along with Pamelia's worsening condition, led the couple to consult the household medical manuals, a common practice for families facing a health crisis. After looking through "all the medical books in the house," they concluded with alarm that Pamelia had cancer. Shortly thereafter, Pamelia and her son Andrew set out on the arduous journey by buggy and train to Helena. The family planned that Pamelia and her daughter Luella would consult with doctors in Helena to learn where Pamelia ought to travel to seek "special treatment."[2]

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[1] Linda Peavy and Ursula Smith, *The Gold Rush Widows of Little Falls: A Story Drawn from the Letters of Pamelia and James Fergus* (St. Paul: Minnesota Historical Society Press, 1990). I was able to piece together the story of Pamelia Fergus's death from information contained in the Peavy and Smith book and from various archival records, primarily family letters located in the following collections: James Fergus Papers, K. Ross Toole Archives, University of Montana, Missoula, Montana (hereafter KRTA-UM); Fergus Family Papers Collection and Oscar O. Mueller Collection, Montana Historical Society Research Center, Helena, Montana (hereafter MHSRC).

The Helena doctors advised against traveling outside of Montana and, according to Luella, argued that "the climate, nursing, & everything here" would instead act in her favour. The surgeons in Helena claimed that they were "just as good" as those in the east at performing the operation that Pamelia required, and her wounds, it was thought, would "heal more readily here." The "nursing" on which the doctors' plan depended would be provided by Luella and her sister, Mary Agnes, both mature, married women with older children. As Luella wrote to her father, "Everybody kind with offers of assistance but we hope we will need no assistance outside the two families. We have a bed in the parlor with everything fixed comfortable for her, & have a girl so have nothing to do but take care of her." In the end, according to Luella, Pamelia "decided for herself" that she did not want to leave Montana, and the operation to remove her breast was performed at

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[2] Letter from James Fergus to Mrs. D.P. Shafer, n.d. 1887, Box 14, James Fergus Papers, KRTA-UM.

Luella's house March 20, 1887.[3] Recovery was slow, and consisted of close and constant nursing attention from Mary Agnes and Luella, while the hired "girl" dealt with domestic chores. Not until early June was Pamelia finally well enough to make the trip back to her beloved ranch.

The mastectomy brought only temporary relief. By the beginning of October Pamelia was once again in an "enfeebled condition" and returned to Helena hoping for another surgical solution. She and James remained optimistic; James drove Pamelia on the 100-mile buggy ride to the train, and then sent her on to Helena by herself. He planned to join Pamelia within a few days, after he had tended to business at the ranch.[4] Although James was undoubtedly concerned about Pamelia's health, he likely had confidence that she would be well cared for by their daughters.

The possibility of a cure for Pamelia's cancer had evaporated by the time she arrived in Helena. There, the doctors found that the cancer had spread to her liver and right ovary. On October 2, Dr. W. L. Steele wrote bluntly to James at the ranch. He advised that "every thing looks very gloomy, we do not expect her to last long and no further operation could be thought of for one minute."[5]

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[3] Letter from Louella Fergus Gilpatrick to James Fergus, 22 March 1887, Box 1, Fergus Family Papers, MHSRC. Sources do not reveal whether the operation that Pamelia endured was a radical mastectomy, or a less intrusive breast removal procedure, but doctors in Helena were likely acquainted with the former as an increasingly popular solution for breast cancer patients. American surgeon William Halsted had been performing the radical mastectomy procedure since 1882, and as Barron Lerner points out, it quickly became the "treatment of choice" for breast cancer. Barron H. Lerner, *The Breast Cancer Wars: Fear, Hope, and the Pursuit of a Cure in Twentieth-Century America* (New York: Oxford University Press, 2001), 17-31. For more on the history of medical treatments related to breast cancer, see Susan Garfinkel, "'This Trial Was Sent in Love and Mercy for My Refinement': A Quaker Woman's Experience of Breast Cancer Surgery in 1814," in Judith Walzer Leavitt, ed., *Women and Health in America,* 2nd ed. (Madison: University of Wisconsin Press, 1999): 68-90; James Olson, *Bathsheba's Breast: Women, Cancer and History* (Baltimore: Johns Hopkins University Press, 2002).

[4] Peavy and Smith, *Gold Rush Widows*, 226.

On October 4, Dr. Steele wrote James that his wife was "rather worse," and that it was "impossible to do anything but palliate and try and make life tolerable as long as it does last."[6] Dr. Steele's use of the word "palliate" is an important clue about health care in the past. It reveals that the concept of palliative care was being employed at least as early as the 1880s. [7] Although few North Americans today are familiar with the concept of palliative care, those who are would likely identify it with the developing international hospice movement of the second half of the twentieth century. This movement was led by Cicely Saunders of Great Britain and Elisabeth Kübler-Ross of the United States, who set out to humanize and de-medicalize the dying process. By the 1970s, hospice advocates, including health professionals and lay persons in both Canada and the United States, sought to address problems associated with institutional care of the dying, care that they believed was inappropriate. [8]

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[5] Letter from W.L. Steele to James Fergus, 2 October 1887, Box 10, James Fergus Papers, KRTA-UM.

[6] Letter from W.L. Steele to James Fergus, 4 October 1887, Box 2, Fergus Family Papers, MHSRC.

[7] The World Health Organization defines palliative care as an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. World Health Organization, "WHO Definition of Palliative Care," http://www.who.int/cancer/palliative/definition/en/, accessed 10 May 2005.

[8] For the history of the hospice movement in North America, see, for example, Cathy Siebold, *The Hospice Movement: Easing Death's Pains* (New York: Twayne Publishers, 1992; Susan L. Smith and Dawn Nickel, "Nursing the Dying in Post-Second World War Canada and the United States," in Georgina Feldberg et al., eds., *Women, Health, and Nation: Canada and the United States Since 1945* (Montreal and Kingston: McGill-Queen's University Press, 2003).

Proponents of hospice approaches argued that care of the terminally ill should be transferred out of acute-care hospitals and into more "home-like" settings, including, but not limited to, the home. In addition, hospice philosophy promoted a more holistic type of care that would alleviate suffering (physical, emotional, psychosocial, and spiritual), rather than emphasize a curative framework. In North America, the terms "hospice" and "palliative care" were used interchangeably to describe an approach to terminal care that focused on the person and not just the disease, an approach that affirmed life and regarded dying as a normal process.[9] Both palliative care and the hospice philosophy emphasized a "team" approach to terminal care, one that would include family participation in the dying process. Some hospice proponents believed that they were inventing a brand new way of caring for the dying, but as the Fergus story attests, they were much less original than they imagined.[10] For over one hundred years, there has been a continuous effort by professional and family caregivers to provide palliative care.

Although we know that Pamelia made the choice to stay in Helena for her cancer treatment, the question of whether or not it was her choice to spend her dying days at her daughter Luella's home is not easy to answer. For one thing, by the time that the doctor determined that there was nothing left to do but provide palliation, her condition had deteriorated so much that she may have been too incapacitated to form a decision around where she wanted to die. Furthermore, sending her back to her own home, if that had been her stated choice, would have been very impractical. Issues around the importance of patient choices related to end-of-life care are often the subject of deliberation in today's world, but we know practically nothing about the role of the patient in the decision-making processes related to terminal care in the past.

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[9] Smith and Nickel, "Nursing the Dying," 331.

[10] Pat Jalland, *Death in the Victorian Family* (New York: Oxford University Press, 1996), 95-96.

Regardless of what she may have chosen or preferred, Pamelia did spend her dying days in Helena, with two of her three daughters providing crucial bedside care as the cancer continued its final, ravaging course. James was not available to provide care or support during Pamelia's last few days of life. It is not clear exactly when James set out for Helena, but he had not arrived by October 6 when Dr. Steele sent a final telegram to the ranch to inform James that his wife had passed away.[11] Despite her daughters' palliative efforts to make her remaining days "tolerable," pain dominated the last days of Pamelia Fergus's life. Lillie, the youngest daughter in Oregon, wrote later that her two sisters had told her "if I could of seen her suffer before she died [I] would be glad to know that it was all over."[12]

Pamelia's story hints at the significance of gender in care of the dying, pointing as it does to the presence of two daughters at the deathbed. The third daughter, Lillie, clearly wanted to care for her mother but circumstances—two small children—not choice, precluded her doing so. In the letter quoted above, she commented on the kindness that her sisters had shown to their mother. For her own part, or lack thereof, Lillie claimed that she would "always feel that I had not done my duty and wish that I could of helped to care for her." Young children meant she was unable to care for Pamelia, but there was also another practical reason. Distance kept Lillie from her mother's side. During

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[11] Peavy and Smith, *Gold Rush Widows*, 226.

[12] Letter from Lillie Fergus Maury to Andrew Fergus, 12 October 1887, Box 1, Oscar O. Mueller Collection, MHSRC.

Pamelia's final illness, Lillie lived nearly 700 miles away from Helena, in Dilley, Oregon.

Unfortunately for Lillie, practical explanations did not relieve her remorse at not joining her sisters to care for her mother. Thus, her perception that she had failed to fulfill her daughterly "duty" compounded the pain of losing her mother. The fact that women suffered, and continue to suffer, such extreme guilt over not being able to provide care to dying family members speaks volumes about the societal and gendered expectations that surround family caregiving. The Fergus family clearly expected that female family members would be the caregivers when Pamelia required nursing after her cancer surgery, and later when she was dying. Andrew and James both transported Pamelia to Helena, but neither was expected to take on the role of caregiver while she was there. Neither was there when Pamelia died. James was either at the ranch or en route to Helena, and Andrew was in Chicago delivering a load of cattle. No correspondence documents whether James or Andrew suffered feelings of guilt over not providing terminal care, but the fact that they were not present at Pamelia's deathbed likely caused them both sadness. In a letter that Andrew wrote to his father shortly after he learned of his mother's death, he expressed his sorrow at not being able to make it to Helena in time for the funeral. Seeing his mother "layed away" would have been a "great satisfaction" explained Andrew. He was, however, comforted by the fact that his father had been able to attend the funeral.[13]

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[13] Letter from Andrew Fergus to James Fergus, n.d., Box 3, James Fergus Papers, KRTA-UM.

Love and affection may have been the reasons that family members cared for dying loved ones, but a strong sense of social and family responsibility also dictated that the sick would be cared for by their family members, almost always women. Issues of care of the dying, where it would take place and who would provide it, were keenly influenced by a cultural ideology that dictated that women were in fact the "natural" caregivers.[14] For the Fergus daughters, the sense of duty to care for their sick mother heightened significantly when Pamelia's death was declared imminent. Circumstances allowed Luella, in particular, to live up to the gendered expectations that she would provide terminal care to her mother, and Mary Agnes was also able to participate in her mother's care.

The Fergus story provides an illustration of part of the history of home care of the dying, especially those with terminal cancer. A mixture of family circumstances and community resources led Pamelia Fergus to first convalesce and then to die at her daughter Luella's home in Helena. Clearly, in this family, caregivers preferred that care take place in the home. Fortunately for Pamelia, two daughters with whom she enjoyed close relationships were willing and able to care for her there.

Class also had an impact on the available care. The family's financial circumstances enabled them to employ domestic help, which in turn allowed the Fergus daughters to concentrate more fully on their mother's care. The Fergus family's relative wealth also meant that they could afford to pay a surgeon to perform Pamelia's mastectomy. Many families would not have been able to afford an operation, even if they believed that surgery was the only option that might keep their loved one alive.

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[14] Nancy R. Hooyman and Judith Gonyea, *Feminist Perspectives on Family Care: Policies for Gender Justice* (Thousand Oaks: Sage Publications, 1995), 121. For further analyses of gender and caregiving in today's society, see Suzanne Gordon, Patricia E. Benner, and Nel Noddings, eds., *Caregiving: Readings in Knowledge, Practice, Ethics, and Politics* (Philadelphia: University of Pennsylvania Press, 1996); Francesca M. Cancian and Stacey J. Oliker, *Caring and Gender* (Walnut Creek, Calif.: AltaMira Press, 2000).

Religion also influenced decisions. Although home surgery was a common practice in the late 1880s, at first glance it seems curious that Pamelia's operation took place outside of a hospital. At the time of her operation, St. John's hospital, a Catholic institution established by the Sisters of Charity of Leavenworth in 1872, was a large and successful enterprise in Helena. Dr. Steele, Pamelia's physician, was one of the more prominent physicians on staff at St. John's.[15] It is possible that Pamelia preferred the more private setting of her daughter's home, and since her daughters were available to provide nursing care, Dr. Steele might also have found it to be a convenient arrangement. The most plausible explanation, however, may have been the personal philosophies of the Fergus family. Staunch agnostics, James and Pamelia Fergus held firm convictions that probably prevented either of them from entering a Catholic hospital for treatment of a serious illness, especially when death was possible or perhaps imminent. The role of religious belief, and its influence on decisions about terminal care, emerges elsewhere in this study.

The story of the Fergus family introduces this dissertation's major themes: gender, place, and palliative care. Pamelia's experiences with illness and death were similiar to those of many Canadians and Americans diagnosed with a terminal illness in the decades before and after the turn of the twentieth century. Typically, if they could afford to do so, persons facing a terminal diagnosis sought some measure of medical care while they hoped or prayed for a cure, but when medical hope was extinguished, issues related to terminal care became paramount. Where one would die depended in large measure upon family resources, but community resources were also important, especially for dying people who lacked family members.

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[15] Paul C. Phillips, *Medicine in the Making of Montana* (Missoula: Montana State University, 1962), 87-89.

CHAPTER ONE

Locating the Care of the Dying in the North American West

This study investigates the history of care of the dying in the American state of Montana and the Canadian province of Alberta between 1880 and 1950. By focusing on these locations over a span of seven decades, it is possible to analyze the practice and politics of care of the dying within specific historical and geographical contexts. This study poses important questions about who has historically made the choices about where dying will take place and who will provide care. As part of that investigation, it examines how the location of terminal care and the availability of caregivers shaped the options of dying people and their families. It explores homes, hospitals, and other locations as sites of terminal care, and identifies the circumstances that ultimately dictated where care would take place. The roles of both informal and professional caregivers are considered, with particular attention devoted to the role of family members as caregivers and to the gendered nature of caregiving.[1]

This dissertation breaks new ground in the history of health care in North America by exploring the care of the dying at home and in hospital. Health care historians have ignored the topic of care of the dying because it was not about efforts to save lives. For example, Judith Walzer Leavitt and Ronald L. Numbers describe the history of health care in America as encompassing "all efforts to cure and prevent illness—lay as well as professional, the failures as well as the successes."[2] Yet, palliation is also an important aspect of health care in the past, as in the present. Indeed, the history of health care in the late nineteenth century and first half of the twentieth century is incomplete if we focus solely on preventative and curative medicine and ignore the history of palliative care.

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[1] In this study, the term "informal" refers to family members and caregivers who were not professionally trained nurses or physicians, and the term "professional" is used to refer to those who were trained nurses and physicians.

To explore the interplay of informal and professional care of the dying, and the locations in which that care took place, this study begins in 1880, a year that historians often mark as the beginning of the modern era of medicine in North America. The tradition of caring for the terminally ill at home did not begin to shift into hospitals until after the end of the Second World War. It was then that the confluence of various health care and social influences—the increasing availability of hospitals, the growth of medical specialization and the decreasing availability of female caregivers in the home—led to a wide scale transfer of terminal care from home to hospital.[3] Thus this study ends in 1950, when about half of all deaths in Canada and the United States took place in hospital.[4]

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[2] Judith Walzer Leavitt and Ronald L. Numbers, eds., *Sickness and Health in America: Readings in the History of Medicine and Public Health*, third ed. (Madison: University of Wisconsin Press, 1997), 3.

[3] Susan L. Smith and Dawn D. Nickel, "From Home to Hospital: Parallels in Birthing and Dying in Twentieth-Century Canada," *Canadian Bulletin of Medical History* 16 (1999): 49-64. For a discussion of the influence of the growth of medical specialization on the relocation of medical care from home to hospital, see David Gagan and Rosemary Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1890-1950* (Montreal: McGill-Queen's University Press, 2002), 35.

[4] National statistics for the United States show that in 1949, 49.5 percent of deaths took place in institutions, the majority in general hospitals: Marilyn J. Field and Christine K. Cassel, eds., *Approaching Death: Improving Care at the End of Life* (Washington: National Academy Press, 1997), 39. Canadian figures show that 50.9 percent of deaths in Canada took place in hospitals in 1950: Donna M. Wilson et al., "Location of Death in Canada: A Comparison of 20th-Century Hospital and Nonhospital Locations of Death and Corresponding Population Trends," *Evaluation and the Health Professions* 24, no. 4 (December 2001): 390.

Many of the historical studies of health care prior to 1950 in both the United States and Canada, not surprisingly, focus primarily on the analysis of professional medical and nursing care and the physical spaces that developed to provide health care treatment. Hence, the literature examines the growth of the medical profession, the rise of the hospital, and those factors that "pulled" patients into hospitals starting in the late nineteenth century.[5] With the advent of germ theory, important developments in laboratory science, technological advances in surgery, and the rising authority of doctors, the hospital more and more became the site where North Americans came to expect excellence in both medical care and medical cure. This emphasis on professions further explains why so little is known about the history of care of the dying, since much terminal care took place in the home and not the hospital, and was provided more often by informal caregivers than professional physicians or nurses. Although the history of health care is heavily weighted toward professional and institutional care, it is not because such care has dominated caregiving.[6]

This study joins the work of those scholars who investigate the significance of the institution of the "family" as the locus of terminal care. Although the number of historical works on the care of the dying in the home is extremely limited, several outstanding historical analyses stress the relevance of the topic of home care to the history of health and medicine, and hint at the importance of the history of care of the dying to health care history, women's and gender history, and social history more generally. Each of these studies forces a reconsideration of the importance of family caregiving.

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[5] Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982); Joel Howell, *Technology in the Hospital: Transforming Patient Care in the Early Twentieth Century* (Baltimore: Johns Hopkins University Press, 1995).

[6] Rather, as Peregrine Horden points out, it is a methodological issue. Peregine Horden and Richard Smith, eds. *The Locus of Care: Families, Communities, Institutions, and the Provision of Welfare Since Antiquity* (London: Routledge, 1998).

In her seminal work, *Death in the Victorian Family*, Pat Jalland explores the experiences of dying, death, grief and mourning in middle and upper class Victorian families in Britain between 1830 and 1920.[7] Most important, Jalland's work points out the different types of medical care that dying persons received in their homes at the hands of both family members and physicians. She clearly establishes that family provision of practical, emotional, and spiritual care to the dying in the home was crucial in circumstances where medical science offered little hope to terminally ill patients. My research builds on Jalland's findings in Britain, yet moves in important new directions by analyzing care of the dying in a North American rural setting, in a later era, and by focusing on families of varying economic classes, not just the wealthy.

In *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History,* Sheila M. Rothman moves patients and families to the center of the history of tuberculosis, the leading cause of death in America during the nineteenth century. [8] Rothman's analysis stands out because she includes the experiences of patients who faced the final, terminal stage of tuberculosis. Working with general archives, mainly family papers, rather than medical archives, Rothman joins social historians who are interested in writing medical history from the bottom up. Rothman thus reveals a great deal about the dying process, the patients who suffered, and the family and community networks that sustained and cared for them. Her portrayal of the physical and emotional suffering endured by consumptives living in the shadow of death effectively and dramatically illustrates the profound trauma that terminal illness visited upon individuals and families.

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[7] Pat Jalland, *Death in the Victorian Family* (Oxford, N.Y.: Oxford University Press, 1996).

[8] Sheila M. Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (New York: Basic Books, 1994).

Ironically, one of the most significant books to have influenced the present analysis focuses on the completely opposite end of the life cycle. In *Brought to Bed: Childbearing in America 1750-1950*, Judith Walzer Leavitt uses family papers and women's diaries to ask pointed historical questions about change and choice in women's childbirth experiences and highlights the power of female networks in the birthing room. During the first third of the twentieth century, birth changed from a female-centered event in the home to a medical event that took place in hospital under physician authority. Leavitt concludes that women chose hospital over home partly because of the declining strength of traditional female networks. In her analysis, this move to hospital accounts for the "single most important transition in childbirth history."[9] However, the transition was gradual. Leavitt shows that doctors started to enter the birthing room as early as 1750, but birth did not move into the hospital until the twentieth century.

Leavitt's work has implications for this study. As with birth, the care of the dying moved from home to hospital only gradually. The hospital was heralded as "the newest and best place for delivery," but what advantages did it offer to the dying patient, whose outcome was already known?[10] Interestingly, while Leavitt maintains that women of means were the first to move into the hospital to give birth, the opposite may have been true for the dying. At the end of life, families with resources may have been better able, as they are today, to pay for the convenience and preference of keeping their loved ones at home.[11]

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[9] Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750-1950* (New York: Oxford University Press, 1986), 195.

In addition to financial resources, gender was a key determinant in whether family members could care for dying people at home. Jalland, Rothman, and Leavitt each offer fascinating and insightful gender analyses in their work, but this dissertation is most profoundly influenced by Emily K. Abel's research on the history of female caregiving in the United States. In *Hearts of Wisdom: American Women Caring for Kin, 1850-1940,* Abel challenges the "persistent assumption that family members lost responsibility for health care after the late nineteenth century."[12] Abel focuses on the chronically ill, but care of the dying does form part of her analysis since during the time period she studies, "sickness was likely to lead to death."[13] Abel demonstrates that there is clearly a history of continuity of family care of the sick in the home, almost all of it provided by female family members. As Abel so effectively illustrates, women's caregiving work was influenced by prevailing gender ideology and extended throughout the life course, as well as throughout the twentieth century.

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[10] Leavitt, *Brought to Bed*, 177.

[11] Susan L. Smith and I have written elsewhere on the parallels related to the history of birthing and dying. See, Susan L. Smith and Dawn D. Nickel, "From Home to Hospital: Parallels in Birthing and Dying in Twentieth-Century Canada," *Canadian Bulletin of Medical History* 16 (1999): 49-64.

[12] Emily K. Abel, *Hearts of Wisdom: American Women Caring for Kin, 1850-1940* (Cambridge and London: Harvard University Press, 2000), 7.

[13] Abel, *Hearts of Wisdom*, 52.

This history of care of the dying draws from and contributes most explicitly to the fields of the history of health care, and women's and gender history, but it is also part of a growing literature that examines death and dying. Despite the proliferation of death studies by sociologists, anthropologists, medical ethicists and religious scholars, few historians of North America in general, and historians of health care in particular, have examined the topic of death and dying. Most of those historians focus on religious aspects of death, or on what took place after death occurred, such as burial or mourning practices. Gary Laderman, a cultural historian who has written two remarkable books, one on American attitudes toward death prior to the twentieth century, and the other on the history of the American funeral home industry, concedes that the subject of death has yet to attain the privileged place in American historiography that it has achieved in European scholarship.[14]

The focus of this study is on care of the dying, and not on the history of death or what took place following death. To that end, the research concentrates on persons who had a terminal illness, especially cancer, but also tuberculosis. Historians of health care who study diseases that were considered terminal during the era they are researching consistently leave out any analysis of the dying process. Tuberculosis and cancer often proved fatal during the period of this study. Yet, most histories of tuberculosis, with the exception of Sheila Rothman's work discussed above, focus on the development of the science of tuberculosis, on public health efforts to eradicate the disease, or on the institutions that housed tubercular patients.[15] Similiarly, most historians who have studied cancer in North America concentrate on the history of the growth of medical knowledge of cancer diagnosis and treatment, and on public health organizations formed to educate the public about the disease. However, two outstanding studies that inform the present study go farther. James T. Patterson's cultural history of cancer in America documents the experiences of cancer researchers, health activists, and to a lesser extent, caregivers – primarily physicians. Patterson also contemplates and contextualizes the patient experience of cancer.[16] Barbara Clow's analysis of how the populace of Ontario, Canada, defined, understood and reacted to cancer prior to 1950 is also exceptional, particularly her insightful attention to patient "choice" and "decision-making" with respect to treatment options.[17]

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[14] Gary Laderman, *The Sacred Remains: American Attitudes Toward Death, 1799-1883* (New Haven: Yale University Press, 1996), 30; Gary Laderman, *Rest in Peace: A Cultural History of Death and the Funeral Home in Twentieth-Century America* (New York: Oxford University Press, 2003). See also, Nancy Isenberg and Andrew Burstein, eds., *Mortal Remains: Death in Early America* (Philadelphia: University of Pennsylvania Press, 2003).

In the present study cancer serves as a focal point for what it reveals about the history of care of the dying. I investigate the patient experience of cancer, but extend that to include terminally ill cancer patients and their caregivers. Since the 1920s, cancer has been the second leading cause of death, after heart disease, in both Canada and the United

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[15] Barbara Bates, *Bargaining for Life: A Social History of Tuberculosis, 1876-1938* (Philadelphia: University of Pennsylvania Press, 1992); Georgina D. Feldberg, *Disease and Class: Tuberculosis and the Shaping of Modern North American Society* (New Brunswick, N.J.: Rutgers University Press, 1995); Katherine McCuaig, *The Weariness, the Fever and the Fret: The Campaign Against Tuberculosis in Canada, 1900-1950* (Montreal: McGill-Queen's University Press, 1999); Katherine Ott, *Fevered Lives: Tuberculosis in American Culture Since 1870* (Cambridge: Harvard University Press, 1996).

[16] James T. Patterson, *The Dread Disease: Cancer and Modern American Culture* (Cambridge: Harvard University Press, 1987).

[17] Barbara Clow, *Negotiating Disease: Power and Cancer Care, 1900-1950* (Montreal and Kingston: McGill-Queen's University Press, 2001).

States.[18] Unlike sudden death from congestive heart failure, death from cancer was often a lengthy and painful process, which complicated and compounded the options available to those with a terminal illness and their family caregivers.

The emphasis on cancer in this study allows one to sharpen the focus of analysis, but locating the history of care for those dying from terminal illness requires that other analytical and methodological boundaries be drawn. Region is another compelling lens through which to study terminal care. "Place" mattered in the history of care of the dying, whether dying took place in the home or a hospital, a rural area or urban center, American state or Canadian province. Some medical historians have recognized the importance of "region" as a key element of place. Ronald L. Numbers points out that medical historians should be aware of the significance of regional thinking and regional developments when writing medical history. However, Numbers warns:

> Our goal as historians is not to celebrate the achievements of a region or to revel in antiquarian detail but to gain a better understanding of the role of place in history. We should also refrain from claiming uniqueness for a region until we first learn what transpired elsewhere. All too often, distinctiveness turns out to be an artifact of ignorance.[19]

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[18] By the second decade of the twenty-first century, cancer is expected to become the number one killer of both Americans and Canadians, surpassing heart disease. Charles Hayter, "Introduction: Special Issue on Cancer," *Canadian Bulletin of Medical History* 20, no. 2 (2003): 252; André Picard, "Cancer Costing Canada Billions," *Globe and Mail*, 14 April 2004.

[19] Ronald L. Numbers, "The Significance of Regions in American Medical History," in Martha L. Hildreth and Bruce T. Moran, eds., *Disease and Medical Care in the Mountain West: Essays on Region, History, and Practice* (Reno: University of Nevada Press, 1997), 3.

Some medical-historical questions can best be answered in a regional context. Numbers and Todd Savitt recognized the importance of region to medical history as early as the 1980s in an edited collection of articles related to science and medicine in the American South.[20] A more recent example of a regional approach to health care history is Sandra Lee Barney's study of the transformation of medical care in Central Appalachia.[21] As Barney notes, the development of professional health care systems in Appalachia was closely linked to broader commercial and economic developments in the region—in particular the arrival of railroads and the rise of the timber and coal mining industries.[22] Regional developments also had significant implications for the types of health care services that North Americans living in the West could access, including terminal care.

Significantly, Numbers's article on regional medicine appeared in an edited collection devoted to the history of disease and medical care in the American mountain West. Like the South, the West is seen as a unique and separate part of the American nation. Martha L. Hildreth and Bruce T. Moran, the editors of the collection, recognize that the concept of the "mountain West" as a distinct geographical and cultural region is open to debate, but they argue that that particular region is clearly defined by a "distinct environment."[23] The early history of the mountain west, characterized largely by its mining and ranching economy, shaped how communities responded to individuals during times of illness and injury. In particular, claim Hildreth and Moran, because the economic structure of the region depended primarily upon successive waves of single men, most early communities "lacked traditional structures of family life," and were therefore unable to depend on the "traditional caretaking skills of women."[24] The present study builds on these arguments about the mountain West, recognizing as regional historians of western North America do, that regions can extend across specific political boundaries. Later economic development, limited health care options, and distinctive demographic characteristics, in particular rurality and a skewed sex ratio, are just a few of the many regional factors that shaped health care in both Montana and Alberta.

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[20] Ronald L. Numbers and Todd L. Savitt, eds., *Science and Medicine in the Old South* (Baton Rouge and London: Louisiana State University Press, 1989).

[21] Sandra Lee Barney, *Authorized to Heal: Gender, Class, and the Transformation of Medicine in Appalachia, 1880-1930* (Chapel Hill: University of North Carolina, 2000).

[22] Barney, *Authorized to Heal*, 3.

[23] Hildreth and Moran, *Disease and Medical Care in the Mountain West*, xiii.

Region has also been a useful analytical tool in the writing of Canadian medical history.[25] Megan J. Davies, for example, takes up the issue of region in relation to health care in British Columbia. She proposes a regional and community centered approach to medical history, in which local variables are central to understanding the evolution of medical professionalism and medical institutions.[26] The present study considers the importance of both region and community. A community can be both a physical site, such as a town or rural district, and a collection of people. By examining sources from both sides of the forty-ninth parallel, it is possible to identify broad regional patterns and pay attention to differences and similarities that arose from the specific national settings and institutional structures of Montana and Alberta. This approach provides the opportunity to make some observations about the role of place in the history of health care and to examine the assertions about health care history most often made based solely on Eastern, urban locations. The regional approach also permits conclusions about whether the experiences of Montanans and Albertans dealing with terminal illness were more alike than different in the era that preceded national health insurance for all Canadians, and Medicaid and Medicare for poor and elderly Americans. [27]

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[24] Hildreth and Moran, *Disease and Medical Care in the Mountain West*, xiv.
[25] Megan J. Davies, "Mapping 'Region' in Canadian Medical History: The Case of British Columbia" *Canadian Bulletin of Medical History* 17, 1-2 (2000): 73-92.
[26] Davies, "Mapping 'Region' in Canadian Medical History," 82.

Despite different national contexts, Alberta and Montana share a regional similarity. They share approximately 200 miles of international border and geographical features such as plains, rivers and mountain ranges. Although there are differences, Montana and Alberta have similar early histories relative to the presence of aboriginal populations and white contact, homesteading and agricultural settlement, railroad companies and towns, as well as cattle and sheep ranching.[28] Both evolved from federal territories, with Montana admitted as the forty-first state in 1889 and Alberta becoming the ninth Canadian province in 1905. In addition to the sometimes shared history and movement of the aboriginal peoples of the region, the early decades of the twentieth century were also marked by back and forth homestead migration across the forty-ninth parallel.[29] Throughout the twentieth century Montana and Alberta have to varying degrees shared multifaceted rural (agricultural) and extractive (mining) economies.

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[27] A few historians of health and medicine have undertaken comparative Canadian/American studies, but virtually all of them reflect on the different roads each nation took. See Georgina D. Feldberg, *Disease and Class: Tuberculosis and the Shaping of Modern North American Society* (New Brunswick, NJ: Rutgers University Press, 1995); Antonia Maioni, *Parting at the Crossroads: The Emergence of Health Insurance in the United States and Canada* (Princeton: Princeton University Press, 1998); Terry Boychuk, *The Making and Meaning of Hospital Policy in the United States and Canada* (Ann Arbor: University of Michigan Press, 1999).

[28] For the general history of Alberta, see Gerald Friesen, *The Canadian Prairies: A History* (Toronto: University of Toronto Press, 1987); Howard Palmer, *Alberta: A New History* (Edmonton: Hurtig Press, 1990). On the general history of Montana, see Michael P. Malone, Richard B. Roeder and William L Lang, *Montana: A History of Two Centuries*, rev. ed. (Seattle: University of Washington Press, 2003).

The population patterns of Montana and Alberta have also been roughly analogous. For example, until 1930, the state and the province had roughly the same number of people (See Table 1). The 1910 U.S. census listed about 376,000 inhabitants in Montana, while the 1911 Canadian census recorded some 375,000 people living in Alberta, and in 1920, Montana claimed approximately 548,000 residents compared to 588,000 in Alberta in 1921. With their settlement booms over, both Montana and Alberta grew more slowly over the next two decades. Montana never regained the economic momentum of the settlement period, but significant migration to Alberta resumed in the 1940s, fed by the petroleum industry. In 1951 there were more than 939,000 people living in Alberta, whereas Montana's population remained just under 591,000 in 1950.

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[29] John W. Bennett and Seena B. Kohl, *Settling the Canadian-American West, 1890-1915* (Lincoln: University of Nebraska Press, 1995), 2; David M. Wrobel and Michael C. Steiner, *Many Wests: Place, Culture, and Regional Identity* (Lawrence: University Press of Kansas, 1997), 12.

Table 1
Census Populations of Montana and Alberta

Year[30]	Montana	Alberta
1900/1901	243,329	73,022[31]
1910/1911	376,053	374,295
1920/1921	548,339	588,454
1930/1931	537,606	731,605
1940/1941	560,002	796,169
1950/1951	591,024	939,501

Source: *The Statistical History of the United States*, Series A 195-209 (New York: Basic Books, 1976), 30; M.C. Urquhart, K.A.H. Buckley, eds., *Historical Statistics of Canada*, Series A2-14 (Cambridge, Eng.: University Press; Toronto: Macmillan, 1965), 14.

Two demographic trends in particular affected the history of health care in the period between 1880 and 1950: rurality and sex ratios. In both Montana and Alberta, rural populations dominated numerically until the 1950s.[32] The sodbusters arrived in the 1890s, when dryland farming techniques, innovations in farm machinery, and rising international wheat prices made farming in semiarid Montana and Alberta an attractive option for those seeking to make a living off of the land. Promotion efforts by railroads, the state, and developers were also instrumental in attracting farmers to these areas.[33] An aggressive immigration promotion campaign launched by Canada's Dominion government in 1896 also enticed settlers to the Canadian West. Immigrants from Europe and elsewhere in North America traveled to Alberta to take advantage of free land available through the *Dominion Lands Act* of 1872 – almost a direct copy of the U.S. Homestead Act of ten years earlier. Between 1901 and 1911, Alberta's population multiplied by over five times.[34] Americans were particularly interested in making the trek, and by 1911 they accounted for 22 percent of Alberta's population.[35] In Montana, the homestead boom began after 1900, and was aided significantly by the *Enlarged Homestead Act* of 1909, which increased the amount of land deeded to each homesteader from 160 acres to 320 acres. A subsequent amendment in 1912 decreased the period over which settlers were required to "prove up" from five to three years. Between 1900 and 1920 the population of the state doubled. Although there were fewer Canadians in Montana than Americans in Alberta, the 1920 census shows that Canadians were the largest group of foreign-born residents in the state.[36]

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[30] The American censuses were taken in the first year of each decade and the Canadian censuses were taken in the next year.

[31] Alberta's 1901 population was included as part of the population for the North West Territories.

[32] Urban Albertans did not outnumber rural dwellers until sometime after 1951; in Montana the urban population did not exceed the rural population until 1960. This was much later than national trends towards urbanization in both countries. In Canada, fifty-one percent of Canadians were urban dwellers by 1921, and in the United States, the urban population also outnumbered the rural population by 1920.

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[33] Laurie K. Mercier, "'You Had to Make Every Minute Count:' Women's Role in Montana Agriculture," in Robert R. Swartout, Jr. and Harry Fritz, eds., *Montana Heritage: An Anthology of Historical Essays* (Helena: Montana Historical Society Press, 1992), 132.

[34] Howard Palmer and Tamara Palmer, *Alberta: A New History* (Edmonton: Hurtig Publishers, 1990), 78.

[35] Howard Palmer and Tamara Palmer, eds., *Peoples of Alberta: Portraits of Cultural Diversity* (Saskatoon: Western Producer Prairie Books, 1985), 11-12.

[36] According to the United States Census, out of the approximately 95,000 foreign-born residents in Montana in 1920, Canadians numbered almost 15,000, Norwegians nearly 10,000, and Swedish and Irish immigrants numbered about 7,000 each. Historical Census Browser, "Ethnicity, Race, Place of Birth," Geospatial and Statistical Data Center,

An unequal sex ratio was a product of the specific type of economic development that emerged in this part of the West. Prior to the emergence of the farmer's frontier, the economic cornerstones of both Alberta and Montana were industries dependent upon a large and steady supply of male workers. Thousands of men, diverse in age, ethnicity and social status, worked in mines, on ranches, or on railroad construction. Because many more men than women went west, Montana and Alberta had skewed sex ratios. For instance, the 1890 census for Montana shows that there were nearly twice as many males as females.[37] In Alberta, the highest discrepancy in the ratio of males to females was recorded in 1911, when there were nearly 150 males for every 100 females.[38] The variance in the sex ratio (the number of males per hundred females) was amplified in particular age groups. For instance, in 1906 the ratio of males to females in Alberta and the other prairie provinces for the 20 to 24 age group was 176 to 100 and in the 25 to 29 age group 180 to 100.[39] This uneven sex ratio had serious implications for a range of health and welfare issues, including care of the dying. Women were expected to provide

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University of Virginia Library, http://fisher.lib.virginia.edu/collections/stats/histcensus/php/start.php?year=V1920#2/, accessed 11 May 2005.

[37] *The Statistical History of the United States*, Series A 195-209 (New York: Basic Books, 1976), 30.

[38] Dominion Bureau of Statistics, *Census of Prairie Provinces 1926, Population and Agriculture Manitoba, Saskatchewan, Alberta* (Ottawa: Printer to the King, 1931), xii-xiii.

[39] Dominion Bureau of Statistics, *Census of the Prairie Provinces 1936* (Ottawa: J.O. Patenaude, King's Printer, 1938), xiii. David T. Courtwright has argued that "frontier" demographics, especially a high sex ratio of males compared to females, underlay the high levels of disease, death and disorder on the American frontier. Courtwright, "Disease, Death, and Disorder on the American Frontier," *Journal of the History of Medicine and Allied Sciences* 46 (October 1991): 457-492.

care to the dying, and address other family and social concerns, yet there were so few of them.

Although this study utilizes primarily a social history approach, it is also informed by historical, psychological, anthropological, and sociological theories of illness and disease. In particular, it draws on Arthur Kleinman's theory of "illness narratives" to analyse the patient and family perspective on disease. Kleinman, a Harvard psychiatrist and anthropologist, has had a profound effect on how historians have analyzed patients, caregivers, and illness. In Kleinman's definition, disease is a biophysical condition, diagnosed and treated by a physician. Illness, he argues, refers to "how the sick person and the members of the family or wider social network perceive, live with, and respond to symptoms and disability."[40] Kleinman states that "the patient's and family's discourse is the original and most fundamental account of illness."[41] But he admonishes:

> [I]llness is not simply a personal experience; it is transactional, communicative, profoundly social. The study of illness meanings is not only about one particular individual's experience; it is also very much about social networks, social situations, and different forms of social reality. Illness meanings are shared and negotiated. They are integral dimension of lives lived together.[42]

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[40] Arthur Kleinman, *The Illness Narratives: Suffering, Healing, and the Human Condition* (New York: Basic Books, 1988), 3-6.
[41] Kleinman, *The Illness Narratives*, 130.
[42] Kleinman, *The Illness Narratives*, 185-186.

As Kleinman points out, illness, including terminal illness, can be a profoundly social experience. Kleinman's concept of "illness narratives" serves as a model in the present study, although the narratives herein are "dying narratives."

Kleinman's view that the meanings of illness are shared and negotiated is a sound theoretical premise, but this study does not focus solely on the cultural and political meanings of disease and dying. A purely discursive approach to the history of disease runs the risk of presenting a picture of illness as solely cultural, with little or no attention to the biological. Some works in the history of disease focus too much on the social construction of disease and do not pay enough attention to the physical realities of disease.[43]

The approach to disease theory in this dissertation draws on the insights of social historians of medicine, such as Charles Rosenberg. Rosenberg analyzes disease by examining how culture and society frames it, and concludes that disease is a social construct, at least in part.[44] Therese Taylor's work on the history of breast cancer also offers a useful model. Taylor draws upon social construction theories of disease, but still insists upon "the organic reality of the disease which takes control, overcoming the social determinants which are left trailing in its wake."[45] Joan Brumberg provides a different model. In her groundbreaking work on the history of anorexia nervosa, Brumberg contends that it is time to recognize the reciprocity of biology and culture. As she claims, illness may be organic, but being sick is a social act.[46] This study focuses on identifying the resources available to the terminally ill and their caregivers. It explores how they coped with and attended to the physical manifestations and related emotional and spiritual aspects of terminal illness, and the contexts in which that care took place.

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[43] An example of this overly discursive approach is David S. Barnes, *The Making of a Social Disease: Tuberculosis in Nineteenth-Century France* (Berkeley: University of California Press, 1995). A very recent example of the discursive approach to disease history is Keith Wailoo, *Dying in the City of the Blues: Sickle Cell Anemia and the Politics of Race and Health* (Chapel Hill: University of North Carolina Press, 2001).

[44] Charles Rosenberg, "Framing Disease: Illness, Society, and History," in *Explaining Epidemics and Other Studies in the History of Medicine* (New York: Cambridge University Press, 1992). I also consider Herzlich's ideas on illness as a social signifier quite useful: Claudine Herzlich, "Modern Medicine and the Quest for Meaning: Illness as a Social Signifier," in Marc Augé and Claudine Herzlich, eds., *The Meaning of Illness: Anthropology, History and Sociology* (Australia and United States: Harwood Academic Publishers, 1995), 151-173.

Like disease, dying is at once a physical, social and emotional process. In 1968, Barney Glaser and Anelm Strauss coined the term "dying trajectory" to refer to dying as a social process with at least two outstanding properties. It has duration, that is, it takes place over time and it has shape, as in it can be predicted. The key to dying trajectories are, according to Glaser and Strauss, that they are "perceived" courses of dying, dependent upon some person identifying another as dying, and subsequently on his or expectations of how dying will proceed.[47] Caregivers determine when a terminally ill person's dying trajectory has begun. They do so by taking note of physiological signs. An increase in the amount of time spent sleeping, and increasing confusion and restlessness during waking moments, are an early indicator that death may be approaching. Death's more immediate imminence is usually marked by irregular breathing patterns, including a breathing pattern called "Cheyne-Stokes" characterized by a struggle for breath followed by cessation of breathing for periods of between ten and thirty seconds. In the later stages, mucus in the mouth accumulates in the back of the person's throat causing them to make a distinct sound, sometimes referred to as the "death rattle." The person may lose control over body fluids, but it is usually more likely that body elimination will simply cease at the end.[48] Although a person's final hours might be fraught with pain, in today's world palliative measures are aimed at assisting the dying person with a pain-free death, which in itself alleviates much of the burden on the caregivers who provide the terminal care.[49] Still, caring for somebody in their final days or hours can be very labour intensive and can provoke a good deal of anxiety in the caregiver.

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[45] Therese Taylor, "'Purgatory on Earth': An Account of Breast Cancer from Nineteenth-Century France" *Social History of Medicine* 11, no. 3 (1998): 381-402.
[46] Joan Jacobs Brumberg, *Fasting Girls: The Emergence of Anorexia Nervosa as a Modern Disease* (Cambridge: Harvard University Press, 1988), 5, 7.
[47] Barney G. Glaser and Anelm L. Strauss, *Time for Dying* (Chicago: Aldine Publishing Company, 1968), 5-6.

This study recognizes that caring for a dying person entails more than tending to the physical manifestations of dying. To that end, it borrows from Martin Bulmer's ideas about the varied components of care. Bulmer suggests that there are three concentric circles of care: 1) "physical tending," which includes face-to-face care 2) "material and psychological" care, which in my definition would include financial and emotional support, companionship, and spiritual care, and 3) "more generalized concern about the welfare of others," which as Bulmer claims could lead to the two types of care above and which I submit would include the offer of, for instance, a prayer or a visit. These types of care might be provided informally by family or friends, and may include paid or professional support.[50] Thus, caregiving work is physical, psychosocial and spiritual.

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[48] Joan Furman and David McNabb, *The Dying Time: Practical Wisdom for the Dying and Their Caregivers* (New York: Bell Tower, 1997), 131-132.
[49] Furman and McNabb, *The Dying Time*, 61-62.
[50] Martin Bulmer, *The Social Basis of Community Care* (London and Boston: Allen & Unwin, 1987), 21.

Sources and Methodology

Attending to the various components of care of the dying as well as to questions about who and where terminal care took place requires that a wide array of archival resources be consulted, from both sides of the forty-ninth parallel. State and provincial health records and reports provide necessary information about community resources available to the dying and their caregivers in Montana and Alberta, including those that pertained to people suffering from cancer or other terminal ailments. Hospital inventories provide detailed statistics and information about cancer care programs initiated on either side of the border after the 1920s. Hospital records are equally important historical sources, especially during the period in this study. Although privacy legislation precludes the discussion of patient particulars in some contexts, quantitative analysis of patient admission and discharge registers is a useful method for identifying terminal cancer patients who were discharged to the home when it was determined that nothing more could be done for them.

Learning about hospital care of the dying is difficult for the historian. Hospital records do exist for both Montana and Alberta, but unfortunately, the nature of record-keeping in hospitals allows few insights into interactions between caregivers and patients. Most records kept during the period of this study were very brief and often recorded only vital signs and medications.

Statistics drawn from death registers provide data on location of death that are persuasive in showing how, overall, death increasingly moved from home to hospital. Yet, there are good reasons to be cautious about reaching historical conclusions about end-of-life care based solely on quantitative sources. As Audrey Ward reminds us, "dying is a process, death an event."[51] Indeed, there is an important methodological distinction to be made when investigating where death took place and where most of the care of the dying took place. For example, hospital registers and similar institutional sources might reveal that persons with terminal cancer died in hospital, yet such deaths may have been incidental to a visit to hospital for the purpose of scheduled or emergency treatment, including surgery. In some cases, the patient may have been cared for at home for a significant period of time prior to his or her admission to hospital. Thus, depending solely on the hospital register as a historical source has the potential of rendering terminal care at home invisible.

Family records, including diaries and letters, have the greatest potential to provide insights into the availability of family resources and the experiences of people dying at home and their caregivers. Primary sources tell the story of care of the dying in the home. Sources used in this study, such as the Slayton diary, or letters such as those left by the Fergus family, are precious, and extremely rare. Diaries and collections of family letters abound for Montanans and Albertans, but months of exhaustive research failed to turn up any other useful dying narratives. Fortunately, some letters by family members exist in the Montana State Hospital Galen Campus Records, and these provide some clues about how family members felt about where terminal care ought to take place, and who ought to provide the care.

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[51] Audrey W.M. Ward, "Terminal Care in Malignant Disease," *Social Science and Medicine* 8, no. 7 (1974): 413.

Obituaries, useful resources for biographical information, also regularly attest to the incidence and importance of family care at the end of life. They have proved to be extremely important sources for this study, and are discussed at greater length in a later chapter. Most of my material about patients and families is drawn from obituaries published about Montanans and Albertans who died of cancer between 1900 and 1950. I also examined death registers, and cancer deaths identified in a mortuary register for Butte, Montana, for the years 1914 through 1918. I also drew on another sample of cancer deaths listed in a ledger from the Orme Funeral Home that recorded a portion of the deaths that took place in the Red Deer, Alberta, district between 1918 and 1936. Finally, I examined cancer deaths recorded at Montana's Galen Tuberculosis Sanitarium between 1926 and 1950.

There are also limitations to the use of qualitative sources. An obituary, for example, might specify that a family member lingered in pain and suffering for six months, but it will not usually mention how family members felt about having to provide care over that length of time. Still, the hundreds of obituaries for cancer victims published in newspapers in Alberta and Montana do provide very personal details about terminal illness and end-of-life care that historians might not otherwise access. When qualitative and quantitative evidence is stitched together, one is able to create a tapestry of the history of care of the dying, even for western, rural communities with limited collections of family papers and medical records.

This dissertation is organized around the key themes of community and family health care and caregiving resources. Chapter Two examines the development of health and hospital services in Montana and Alberta from territorial times to the mid-twentieth century. It provides a context for understanding the options, choices and contingencies that influenced care of the dying, in both the early and late phases of terminal illness. Understanding the development of health programs and hospital services provides evidence of what community resources were available and when. [52] The increasing availability of health services to the subjects of my study, predominantly white westerners, did not translate into increased accessibility for all Montanans and Albertans. In particular, Native North Americans were restricted to specific federally funded native hospitals and health programs. The history of care of the dying in Native North American communities is a deserving topic that awaits further attention. [53]

Chapter Three considers the treatment and hospitalization options for patients who suffered from terminal tuberculosis or terminal cancer during the first half of the twentieth century in Alberta and Montana. The analysis in this chapter puts to the test, in the context of the North American West, the claim made by Charles Rosenberg that hospitals of the early twentieth century were "unwilling to admit patients who suffered from chronic diseases such as tuberculosis and cancer."[54] If hospitals would not take them, where did people who were suffering from cancer or tuberculosis go to be treated or to die?

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[52] There has been little written on the history of health and medicine in either Montana or Alberta. For a history of the medical profession in Montana during the territorial or "frontier" period, see Phillips, *Medicine in the Making of Montana*. For Alberta, see Heber C. Jamieson, *Early Medicine in Alberta: The First Seventy-Five Years* (Edmonton: Douglas Printing Company, 1947).

[53] The history of aboriginal health prior to the white settlement period in Alberta and Montana has not received a full analysis, but a few authors have touched briefly on the topic. In Montana, see Phillips, *Medicine in the Making of Montana*, 1-19. In the Canadian Plains area, which includes parts of Alberta, see Maureen K. Lux, *Medicine That Walks: Disease, Medicine and Canadian Plains Native People, 1880-1940* (Toronto: University of Toronto Press, 2001). For works that discuss federal programs related to the health of Native North Americans in Canada or the United States between 1880 and 1950, see James B. Waldram, D. Ann Herring and T. Kue Young, *Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives* (Toronto: University of Toronto Press, 1995); Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-1950*. Vancouver: University of British Columbia Press, 1998; Robert A. Trennert, *White Man's Medicine: Government Doctors and the Navajo, 1863-1955* (Albuquerque: University of New Mexico Press, 1998).

Chapter Four explores the role of family in care of the dying, with particular emphasis on the gendered nature of care. Employing gender as a category of historical analysis helps to explain why some family members took on the role of caregiver and why others did not. Viewing terminal care through a gendered lens also allows one to participate in a debate established by early historians of the North American West. In that debate, historians have traditionally disagreed over whether gender norms were more relaxed in newly settled "frontier" communities. The present study will provide some insights into that question. Some historians have argued that gendered expectations were different for women in the American West than the East, and that western women were allowed or even encouraged to exceed traditional gender expectations. [55] Other historians argue that women in the West were just as strongly influenced by traditional gender norms as women elsewhere in the United States.[56]

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[54] Charles Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (Baltimore: Johns Hopkins University Press, 1987), 113, 306. Hospitals were reticent to admit tuberculosis patients not only because the patients might die, but also because tuberculosis was a highly contagious disease.

[55] See, for example, Sandra L. Myres, *Westering Women and the Frontier Experience, 1800-1915* (Albuquerque: University of New Mexico Press, 1982).

[56] For these discussions, see John Mack Faragher, *Women and Men on the Overland Trail* (New Haven: Yale University Press, 1979); Julie Roy Jeffrey, *Frontier Women: "Civilizing" the West? 1840-1880*, rev. ed. (New York: Hill and Wang, 1998). For a similar discussion in the Canadian context, see Veronica Strong-Boag, "Pulling in

Chapter Five provides the Slayton case study, which chronicles one family's painful journey through terminal illness during the late 1920s. It offers a closer look at the role of the patient in his or her own care during the early terminal phase, the transition that the terminally ill made to being cared "for," and the network of caregivers who provided support to the dying in the home, including professional care by physicians and trained nurses.[57] An obituary found in a collection of family papers led to the discovery of a diary kept by Daniel Slayton, a sixty-five-year-old-man living in Lavina, Montana, who was diagnosed with terminal bone cancer in 1927. An illness and dying narrative is presented in Daniel's diary, first by Daniel and then by his wife. The Slayton case study considers the roles of lay and professional caregivers who accompanied Daniel Slayton through the dying process, a trajectory that was understood to be as much a social and spiritual process as a medical one.

In Montana and Alberta, over the span of seven decades, terminally ill people and their families inhabited a type of borderland of their own. Crossing between home and hospital, from curative treatment to palliative treatment, between hope and pain, and from the land of the living to the land of the dying, patients and loved ones traversed a landscape that was fraught with suffering, frustration, and heartache. Doctors may not have been able to cure, and a family's resources and love might not have kept the grim

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Double Harness or Hauling a Double Load: Women, Work and Feminism on the Canadian Prairie," *Journal of Canadian Studies* 21, no. 3 (1986): 32-52.

[57] Daniel Slayton diary, Daniel Webster Slayton and Lizzie Ellis Slayton Papers, Montana Historical Society Research Center, Helena.

reaper from the door indefinitely, but there was always "something" that could be done to aid the dying on their final journey.

CHAPTER TWO

Community Resources: Hospitals and Health Services In Montana and Alberta

To more fully comprehend the options available to dying people and their families, this chapter traces the development of community resources, focusing on hospitals and health services in Alberta and Montana between 1880 and 1950. It examines the types of health services that individuals, communities or governments were willing to fund and develop, and the types of patients and diseases that hospitals were willing to treat. It demonstrates that, despite some national differences, similar community resources were available to meet health care needs in both Alberta and Montana. Furthermore, women were behind the development of much of these resources.[1] These health and hospital resources were directed toward the recovery or promotion of good health, and not at ensuring a good death. Yet, they sometimes proved to be valuable to end-of-life care.

Throughout the late nineteenth century and first half of the twentieth, the doctors and managers of most hospitals in North America preferred not to admit dying patients.[2]

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[1] Historians have recognized women's efforts with respect to developing health resources. See, for example, Judith Walzer Leavitt, *The Healthiest City: Milwaukee and the Politics of Health Reform* (Princeton: Princeton University Press, 1982); Susan. L. Smith, *Sick and Tired of Being Sick and Tired: Black Women's Health Activism in America, 1890-1950* (Philadelphia: University of Pennsylvania Press, 1995); Dianne Dodd and Deborah Gorham, eds., *Caring and Curing: Historical Perspectives on Women and Healing in Canada* (Ottawa: University of Ottawa Press, 1994).

[2] Charles Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (Baltimore: Johns Hopkins University Press, 1987), 113, 306; David Gagan and Rosemary Gagan, *For Patients of Moderate Means: A Social History of the Voluntary*

Regardless of whether a hospital was a cottage institution in a small town or rural area, or a large, modern urban institution in New York or Montreal, hospitals focused on the provision of acute care, not palliative care. As late as 1945, a group of social workers studying the care of two hundred terminally ill patients in Boston concluded:

> It is well known that hospitals have to discourage or refuse both admission and holding of patients who are untreatable and in the terminal stage.[3]

Similarly, physician-educator Ian R. McWhinney, reflecting on his former experience in family practice, asserts that as late as the 1950s "there was no expectation that dying patients would be admitted to the hospital."[4] Prior to 1950, most Canadians and Americans viewed care of the dying as a private family matter to be handled in the home, not as a public health or medical matter requiring government support.

In the late nineteenth and early twentieth centuries, health issues related to the beginning or middle of the life cycle received more attention than those at the end. Premature death was an ever-present fact of life and Albertans and Montanans constantly faced the threats posed by epidemics of infectious and contagious diseases and by high

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Public General Hospital in Canada, 1890-1950 (Montreal: McGill-Queen's University Press, 2002), 8.

[3] Ruth Abrams et al., "Terminal Care in Cancer: A Study of Two Hundred Patients Attending Boston Clinics," *New England Journal of Medicine* 232, no. 25 (1945): 721.

[4] Ian R. McWhinney, "The Doctor, the Patient, and the Home: Returning to Our Roots," *Journal of the American Board of Family Practice* 10, no. 6 (1997): 430. Dr. McWhinney is Professor Emeritus of Family Medicine at the Centre for Studies in Family Medicine at The University of Western Ontario, and a specialist in family medicine and palliative medicine.

maternal and infant mortality rates. In addition, male Montanans and Albertans disproportionately worked in mining, North America's most dangerous industry.

Health Services

In the late 1800s, health care services in the Montana territory and Alberta, at that time part of the North-West Territories, looked very similar. In both places, the vast distances between population centers, as well as the scarcity of nurses, physicians, and hospitals, served as barriers to the development and delivery of public health or medical services.[5] Public health matters were handled within local jurisdictions and consisted primarily of efforts to deal with crises such as outbreaks and epidemics of infectious and contagious diseases.

Statehood in Montana after 1889 and provincial status in Alberta after 1905 did not mark the onset of dramatic differences in the delivery of health care services. For one thing, the diseases and other health issues that arose remained similar in both places. As with the rest of North America, the most aggressive public health efforts were concentrated in urban areas and focused primarily on epidemic, not endemic disease.[6] In both Montana and Alberta, smallpox epidemics precipitated the creation of state and provincial Boards of Health. The Montana State Board of Health was created on March 16, 1901.[7] At that time, health officials struggled to deal with issues related to smallpox vaccination and quarantine that were as contentious as the disease was contagious.[8] Alberta's Provincial Board of Health was established under the jurisdiction of the Department of Agriculture as part of the *Public Health Act* assented to in March 1907. By continuing the work of an earlier and smaller territorial department, the province hoped to get a firmer grip on the health conditions of a rapidly growing population. One of the board's primary purposes was public health inspection. To that end, provincial health inspectors devoted themselves to the regular inspection not only of slaughterhouses and piggeries, but also of jails, schools, churches, and hospitals. Government inspection of provincial hospitals in Alberta was the only apparent difference from Montana in health policy matters at the turn of the twentieth century.

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[5] For more on the early history of health and medicine in Alberta and Montana, in particular the history of physicians, see Heber C. Jamieson, *Early Medicine in Alberta: The First Seventy-Five Years* (Edmonton: Douglas Printing Company, 1947); Paul C. Phillips, *Medicine in the Making of Montana* (Missoula: Montana State University Press, 1962).

[6] As Judith Walzer Leavitt pointed out in her work on health reform in Milwaukee, chronic and endemic diseases did not receive the attention that epidemic diseases did, despite the fact that chronic disease was responsible for more deaths. Leavitt, *The Healthiest City*. For more about American public health history and the different public health approaches to epidemic versus endemic diseases, see John Duffy, "Social Impact of Disease in the late 19th Century," *Bulletin of New York Academy of Medicine* 47 (1971): 797-811; Charles E. Rosenberg, *Explaining Epidemics and Other Studies in the*

By about 1915, two differences in Alberta and Montana's health care programming can be discerned. The first related to the degree of government intervention in hospital development, with the Alberta government clearly more engaged in building, supporting, and monitoring hospitals and hospital services. As Terry Boychuk points out

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History of Medicine (New York: Cambridge University Press, 1992). For more on urban public health in Canada, see Heather MacDougall, "Public Health and the 'Sanitary Idea' in Toronto, 1866-1890," in Wendy Mitchinson and Janice Dickin McGinnis, eds., *Essays in the History of Canadian Medicine* (Toronto: McClelland and Stewart, 1988), 62-87.

[7] On the formation of the Montana State Board of Health see Ellen Leahy, "'Montana Fever:' Smallpox and the Montana State Board of Health," *Montana* 53, no. 2 (2003): 32-45.

[8] George Rosen, *A History of Public Health,* rev. ed. (Baltimore: Johns Hopkins University Press, 1993), 76, 162-167, 255; Leavitt, *The Healthiest City*, 76-121.

in a comparative analysis of hospital policy in the United States and Canada, local governments in the Prairie provinces of Canada were exceptional in their readiness to assume direct responsibility for hospital care.[9] In 1898, the government of the North-West Territories passed *An Ordinance to Regulate Public Aid to Hospitals*. Starting that year and continuing through the next sixty years, each approved hospital in Alberta was eligible to receive a per diem payment for every patient admitted. The per diem rate ranged from twenty-five to fifty cents per patient per day. Approved hospitals included religious, community, and government hospitals, but with few exceptions excluded private hospitals owned by individuals. Hospitals were paid their subsidies twice a year, based on their provision of sworn vouchers. Since they were potentially eligible for a subsidy, hospitals in Alberta were also exposed to surveillance, and from the time that the hospital ordinance was passed in 1898 through the first half of the twentieth century, inspectors for the Department of Public Health visited most Alberta hospitals on a regular basis.[10]

Prior to 1945, Montana state health officials exhibited a completely laissez-faire attitude toward the existence and business of hospitals in the state, and most hospitals in Montana operated without government support or surveillance. By 1915, officials from the State Board of Health regularly inspected hotels, restaurants, slaughterhouses, confectioneries and bake shops, and licensed only those establishments that met the conditions of sanitary inspection. However, hospitals in the state were not subjected to inspection or licensing until 1941, when a law regarding maternity hospital licensing was passed that dictated that all hospitals in the state receiving maternity patients be inspected and licensed. Even that program was curtailed by 1945, due to lack of personnel. The reasons that Montana hospitals operated for so many decades without state oversight remain unclear, but a shortage of inspection personnel played a large part.[11]

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[9] Terry Boychuk, *The Making and Meaning of Hospital Policy in the United States and Canada* (Ann Arbor: University of Michigan Press, 1999), 42.

[10] North-West Territories, Department of Agriculture [hereafter called North-West Territories, DOA], *Annual Reports 1898-1904* (Regina: John A. Reid); Alberta, Department of Public Health [hereinafter, DPH], *Annual Reports 1906-1950* (Edmonton: various publishers).

Montana's lack of personnel was at least partly due to lack of funding for health matters in the state. Indeed, the second difference between Alberta and Montana in the area of hospital development relates directly to government financial support. In the United States, the federal government launched major health care programming, especially for maternal and infant care in the 1920s and more widely after the onset of the Depression; in Alberta, major health care initiatives remained primarily a provincial responsibility, with some federal participation to share costs coming later in the century. At the state level in Montana, health care may have been a concern to both the Populists who held political sway from the late 1880s to the turn of the new century and to the Progressives who made their influence felt in the decades leading up to the Depression, as well as to the Republicans who prevailed thereafter. Further research is needed to fully assess Montana's political commitment to health care provisions.

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[11] Evidence suggests that the Board's efforts were frequently hampered by its small staff, a bad situation that only worsened as the century wore on. For example, in 1923, the Board had to let go the only professional epidemiologist on its staff, due to lack of money. Montana, State Board of Health [hereafter SBH] *Twelfth Biennial Report 1923-1924* (Helena: Independent Publishing Co., 1924), 4.

Despite diverse political philosophies, the three consecutive provincial governments that held power in Alberta prior to 1950 appeared to be committed to making health care a priority. When elected in 1905, Alexander Rutherford and his Liberal cabinet understood that as part of Canada's western hinterland, Alberta was expected to serve national and imperialist interests.[12] A healthy and growing population was absolutely necessary to meet those expectations. The federal Liberals were instrumental in encouraging and supporting the development of health programs by their provincial counterparts, but pressure from the populace was even more important.

The differences in government response to health issues in Alberta and Montana were no doubt related to the power of the United Farmers of Alberta (UFA).[13] Over the first decade and a half of Alberta's provincehood, the UFA and especially the United Farm Women of Alberta (UFWA) pressured the governing provincial Liberals to keep health care a priority. The UFWA successfully lobbied the government to pass a flurry of health-related legislation during the second decade of the new century. Most of the new health programs were aimed at improving conditions for birthing women, infants, and children. By 1921 the UFA had formed its own political party and had successfully wrested power from the provincial Liberals. As Paul Victor Collins has shown, by the time it was elected, the UFA had, with the instrumental assistance of the UFWA, fashioned a new public understanding of health problems, as well as a desire among Alberta's population for government solutions to those problems.[14] Throughout its political tenure between 1921 and 1935, the UFA promoted the ideal of accessible and affordable medical care to people all across Alberta, with special attention paid to the party's largely supportive rural base.

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[12] Doug Owram, *Promise of Eden: The Canadian Expansionist Movement and the Idea of the West, 1856-1900* (Toronto: University of Toronto Press, 1980).

[13] The UFA was formed in 1909, when two farmer organizations, the Society of Equity and the Alberta Farmers Association, joined together. For more on the activities of the United Farmers of Alberta and its influence on provincial health politics, see Paul Victor Collins, "The Public Health Policies of the United Farmers of Alberta Government, 1921-1935" (Masters Thesis, University of Western Ontario, London, Ontario, 1969); Bradford James Rennie, *The Rise of Agrarian Democracy: The United Farmers and Farm Women of Alberta, 1909-1921* (Toronto: University of Toronto Press, 2000).

By the late 1910s, widespread infectious and contagious disease outbreaks and epidemics had generally abated in Alberta and Montana. The scourge of smallpox had receded, as had the terror of typhoid, and the use of antitoxin for diphtheria was doing much to eradicate that disease.[15] Unfortunately, the worst was yet to come, with nobody prepared for the havoc brought on by the arrival of the influenza pandemic. [16] The worldwide pandemic was brief but deadly, killing millions of people in a matter of months. The populations of Montana and Alberta were dominated by young adults, the exact cohort that the flu attacked most severely, and the manifestation of the disease in the bodies of many young Albertans and Montanans sudden and swift. The first cases of influenza in Alberta were reported in October 1918.[17] By the end of 1919 there were 38,000 reported cases with over 4,000 fatalities.[18] Montana was also hit hard, with 37,000 cases and 5,000 deaths over the same two-year period.

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[14] Collins, "The Public Health Policies of the United Farmers of Alberta Government," 16.

[15] For discussions of public health efforts dealing with diphtheria in Canada, see Jane Lewis, "The Prevention of Diphtheria in Canada and Britain 1914-1945," *Journal of Social History* 20, no. 1 (1986): 163-176; Catherine Braithwaite, Peter Keating, and Sandi Viger, "The Problem of Diphtheria in the Province of Quebec 1894-1909," *Histoire Sociale* 29, no. 57 (1996): 71-95. In the American context, see Jonathan M. Liebenau, "Public Health and the Production and Use of Diphtheria Antitoxin in Philadelphia," *Bulletin of the History of Medicine* 61, no. 2 (1987): 216-236; Evelynn Maxine Hammonds, *Childhood's Deadly Scourge: The Campaign to Control Diphtheria in New York City, 1880-1930* (Baltimore: Johns Hopkins University Press, 1999).

[16] For an overview of the pandemic's history in America, see Alfred W. Crosby, *America's Forgotten Pandemic: The Influenza of 1918* (Cambridge: Cambridge University Press, 1989). For a brief discussion of the pandemic in Canada, see Eileen Pettigrew, *The Silent Enemy: Canada and the Deadly Flu of 1918* (Saskatoon: Western Producer Prairie Books, 1983).

When the catastrophic flu was behind them, the Boards of Health in both Alberta and Montana began to focus on other longstanding public health problems. The most pressing health concerns facing both Montana and Alberta by the late 1910s were related to the care of birthing mothers and newborn infants. In Canada, as in the United States, the onset of the First World War in 1914 had brought to light the poor health of its military recruits, pulling issues of health and welfare to the forefront of each nation's consciousness. By the late 1910s, progressive reformers and women's rights advocates in and outside of government all across North America had identified the need to address critical health issues at the beginning of the life cycle. Montana and Alberta were no exception. Appalling statistics on maternity related deaths caused deep concern among both state and provincial health officials. For example, Montana State Board of Health officials claimed that Montana was in the "unenviable position" of having the highest reported maternal mortality of any state included in the national statistics in 1919, and the highest [illegible]ant mortality rate of any of the states in the American North-West.[19] Similiarly, by 1921 Alberta had the highest recorded maternal and infant mortality rates in Canada[20] (See Table 2).

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[17] Alberta, DPH, *Annual Report 1918* (Edmonton: J.W. Jeffery, 1919), 9.

[18] Janice Dickin McGinnis, "A City Faces an Epidemic," *Alberta History* 24, no. 4 (1976): 1-11; Alberta, DPH, *Annual Report 1920* (Edmonton: J.W. Jeffery, 1921), 9.

[19] Montana, SBH, *Twelfth Biennial Report 1923-1924*, p.37. Claims that Montana had the highest maternal rate in the country must be approached with caution. Prior to 1933, when the United States adopted uniform registration procedures for death and disease reporting, health statistics for the country were often incomplete and inconsistent. Judith W. Leavitt and Ronald Numbers, *Sickness and Health in America: Readings in the*

In Alberta and Montana, as in most of the rest of North America, women drove the movement for better maternal and child health. Public health officials generally took a two-pronged approach to improved maternity care in Alberta. The first was to focus on the provision of health care services to women who delivered their babies at home in isolated communities and rural areas. In small towns and on farms, the infant mortality rates were appalling, often twice or more than the city rates.[21] The second approach was to increase the availability of hospital-based maternity care. The two major legislative initiatives were the *Municipal Hospitals Act* of 1917, and the *Public Health Nurses Act*, passed in 1919.

While the latter went far toward providing public health services in urban centers, it did nothing to lower the high death rates associated with childbirth in the isolated rural communities, most of which were without nurses, doctors, or hospitals. To address those specific needs, the UFWA submitted a proposal to the provincial government for a District Nursing Program, believing that the rural areas could also benefit from the types of services being provided in the cities. The government moved quickly to enact it in

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History of Medicine and Public Health, 3rd ed. (Madison: University of Wisconsin Press, 1997), 3.

[20] Nanci Langford, "Childbirth on the Canadian Prairies 1880-1930," *Journal of Historical Sociology* 8, no. 3 (1995): 289; Nanci Langford, *Politics, Pitchforks and Pickle Jars* (Calgary: Women of Unifarm and Detselig Enterprises, 1997), 60-68.

[21] Alberta, DPH, *Annual Report 1936* (Edmonton: A. Shnitka, 1938), 14; Langford, "Childbirth on the Canadian Prairies," 299, n. 7.

1919, making Alberta only the second province in Canada to establish such a program.[22] The program was tailor-made to address the health needs of farm families and provided not only public health services, such as school inspections and immunizations, but also natal care before, during and after birth, emergency care and even dentistry and veterinary services. The salaried nurses, who were employees of the provincial government, were the only nurses allowed to practice midwifery legally in Alberta after 1919. Midwifery was just one example of the expanded role and authority that these nurses enjoyed. Efforts to continue to improve birthing conditions for Alberta women stalled during the economic depression of the late 1920s and early 1930s, but the provincial government's commitment to improving maternity care was revived in April 1944, when the Social Credit government's *Maternity Hospitalization Act* went into effect, guaranteeing free hospital services for new mothers and infants.

Montana lacked both the money and the strong lobbying power of an organization such as the United Farm Women of Alberta. The problem of high maternal and infant mortality rates was not given much priority until 1921 when the federal government passed the *Sheppard-Towner Act*. The act, which promoted health and welfare for expectant mothers and infants, made funds available to states in proportion to population, if the state committed matching funds. Funding was stretched over five years, and each participating state also received an additional gift of $5000.[23] The Sheppard-Towner program was in place in Montana by May 1922, and was administered by officials from the Montana State Board of Health's Division of Child Welfare. The state legislature's matching amount was almost $9000, which meant the budget for the five-year period was just under $23,000. Much of the first year was devoted to promoting the program to physicians as well as the public and trying to improve an inadequate birth and death registration system.[24] The act required proper statistical reporting, including accurate knowledge of mortality rates. The emphasis that health officials placed on vital statistics was in keeping with a wider medico-scientific movement initiated during the nineteenth century which sought to collect, study, and apply numerical data in pursuit of public health knowledge.[25] In Montana, better vital statistics reporting after 1920 often provided the proof necessary to secure federal health funding, while in Alberta, vital statistics reporting had been considered an important priority since before the turn of the twentieth century.[26]

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[22] The first province to establish a district nursing program was Saskatchewan, which, like Alberta, shared a border and demographic similarities with Montana. Sharon Richardson, "Political Women, Professional Nurses, and the Creation of Alberta's District Nursing Service, 1919-1925," *Nursing History Review* 6 (1998): 25-50.

[23] For discussions of the Sheppard-Towner program, see, J. Stanley Lemons, "The Sheppard-Towner Act: Progressivism in the 1920s," *Journal of American History* 55, no.

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4 (1969): 776-786; Molly Ladd-Taylor, *Mother-Work: Women, Child Welfare, and the State, 1890-1930* (University of Illinois Press, 1995); Kriste Lindenmeyer, *"A Right to Childhood": The U.S. Children's Bureau and Child Welfare, 1912-1946* (Urbana: University of Illinois Press, 1997).

[24] Frances S. Bradley, MD, "Why a Child Welfare Division in the State Board of Health?" *Northwest Medicine* 25, no. 3 (1926), 150.

[25] James H. Cassedy, *American Medicine and Statistical Thinking, 1800-1860* (Cambridge: Harvard University Press, 1984), vii.

[26] Provincial health officials in Alberta invested almost as much energy in compiling and interpreting statistics as they did in monitoring and dealing with outbreaks and epidemics. For instance, during an eight-month period in 1908, the provincial medical inspector traveled a total of 12,000 miles (approximately 9,800 by rail and 2,200 by road) in order to gather statistics related to births, diseases, and deaths, to inspect hospitals and only incidentally, it seemed, to monitor outbreaks of contagious and infectious diseases. Alberta, DPH, *Annual Report 1908* (Edmonton: Jas. E. Richards, 1910), 184.

Although few in number, the women who administered the Sheppard-Towner program in Montana, many of whom were physicians and nurses, were as committed as the UFWA women in Alberta to the idea that rural populations deserved the same level of maternity and health care services as that provided to the urban population. To realize their goals, these women attempted to garner support for the development of a country nursing system that would have paralleled the district nursing system in Alberta.[27] In July 1925, Dr. Frances S. Bradley of Helena, Director of the Division of Child Welfare, addressed the annual meeting of the Montana Medical Association and urged doctors to support both the implementation of a county nursing program, and the continuance of the Sheppard-Towner program, which was at that time halfway through its five-year tenure. She recited the unfortunate incident of a woman in labour from rural Montana who, while being transported in a rough lumber wagon to the nearest town, had given birth to a stillborn child on the side of the road and whose husband had then, without securing either medical or nursing assistance, "jolted the mother with her dead child back to the little saw mill shack."[28] The unfortunate incident could have been prevented, claimed Dr. Bradley, had there been a county nurse available. But the Sheppard-Towner program was discontinued in Montana at the end of its initial five-year term, and the county nursing scheme never did materialize. Although there may have been some support for both plans, the desperate economic conditions that persisted in Montana throughout the 1920s and 1930s likely prevented the implementation of the new plan, and the Sheppard-Towner program was repealed nationally in 1929 due to pressure from organized medicine. Additionally, even if a county nursing program had been created, a nursing shortage that existed in Montana for most of the first half of the twentieth century would have limited its possibilities.[29]

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[27] For literature dealing with state or district nursing programs in another part of the United States, see Nancy Schrom Dye, "Mary Breckinridge, the Frontier Nursing Service and the Introduction of Nurse-Midwifery in the United State," *Bulletin of the History of Medicine* 57, no. 4 (1983): 485-507.
[28] Bradley, "Why a Child Welfare Division," 147.

Overall, infant and maternal mortality rates improved in Alberta and in Montana between 1920 and 1950 (See Table 2). Although historians disagree about whether or not the hospitalization of birth contributed to the drop in infant and maternal mortality rates during the second quarter of the twentieth century, medical professionals of the era clearly believed hospitalization would improve rates.[30] Health experts urged women to go to hospitals to give birth and many Alberta women listened, especially after they were guaranteed free care in hospital. In 1938 about sixty-six percent of births in Alberta took place in hospital and by 1949 over ninety-seven percent of Alberta's babies were born in hospitals, many of them in Alberta's municipal hospitals.[31]

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[29] Montana Nurses Association, *Nursing in Montana* (Great Falls, Mont: Tribune Printing, 1961), 91. In Alberta, a nursing shortage began with the onset of the Second World War, according to Janet C. Ross-Kerr, *Prepared to Care: Nurses and Nursing in Alberta* (Edmonton: University of Alberta Press, 1998), 58. Nursing shortages during the first half of the twentieth century may not have been unique to Montana and Alberta. Further research needs to be done to assess shortages in the American context, but for the Canadian context see Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990* (Toronto: Oxford University Press, 1996), 6, 206-208, 231.

[30] For a discussion of the decline in Canadian maternal mortality rates, see Wendy Mitchinson, *Giving Birth in Canada, 1900-1950* (Toronto: University of Toronto Press, 2002), 283-284.

[31] Alberta, DPH, *Annual Report 1938* (Edmonton: A. Shnitka, 1939), 6; Alberta, DPH, *Annual Report 1950* (Edmonton: A. Shnitka, 1952), 95.

Table 2
Infant and Maternal Mortality Rates
Alberta and Montana[32]
1920-1950

Year	Infant Mortality Alberta (deaths under 1 year of age per 1000 live births)	Infant Mortality Montana	Maternal Mortality Alberta (deaths of mothers per 1000 live births)	Maternal Mortality Montana
1920	93	72	Not available	8.8
1925	72	70	Not available	8.1
1930	63	57	6.5	6.7
1935	58	60	4.3	5.2
1940	48	46	3.9	3.4
1945	43	34	2.4	1.4
1950	32	26	0.7	0.6

Source: Alberta, DPH, *Annual Reports* 1920-1950; Montana, SBH, *Biennial Reports*, 1923-1950.

The improvements in maternal and infant health were welcome at a time when Montana and Alberta, like other parts of North America, faced the effects of a deepening economic crisis that started in the 1920s and did not abate until the mid-1940s. Poverty increased health problems, with families less and less able to afford the costs of health care as the economic depression worsened. Although the impact of the New Deal on health care in Montana awaits further research, Michael Grey's study of the rural health programs introduced by the New Deal's Farm Security Administration (FSA) between 1939 and 1941 suggests that at least a few Montana counties participated in one or more of the new medical care programs.[33]

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[32] It is not clear from the statistical reporting on infant and maternal mortality in either Alberta or Montana whether the statistics include children born to Native North American mothers, but the fact that Native health issues and reporting fell under federal, and not state or provincial, jurisdiction makes it likely that the statistics excluded Native mothers and babies.

Overall, at the state level in Montana, health issues not related to maternal or infant health were not a priority until 1945, when the federal government launched another major health initiative with its Hill-Burton program. The program injected funds into states that, after meeting certain requirements, became eligible for a grant to aid in hospital construction.[34] In Montana, the participants involved in implementing the Hill-Burton initiative appear to have been influenced by health care discussions taking place north of the border. In a 1949 report stressing the need for a coordinated hospital-health-medical care program in Montana, the chairperson of the Hill-Burton program, rural sociologist Carl F. Kraenzel, made explicit reference to the Saskatchewan Health Services Survey Committee Report that had been completed in 1944.[35]

In Alberta, the devastating conditions of the Depression were in large part responsible for the defeat of the UFA in 1935. When the Social Credit government took over the province, they kept health care a priority, and despite the trying economic times, continued to expand health care programs.[36] Again, legislative acts expanded health care options for Albertans at both ends of the life cycle, especially in relation to location of health care. In particular, legislation made tuberculosis and cancer care in clinics and hospitals free for all Albertans, in 1936 and 1940 respectively. In addition, free hospital care for pregnant women was introduced under the *Maternity Hospitalization Act in* 1947, the same year that free hospitalization was guaranteed to old age pensioners.

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[33] Michael R. Grey, *New Deal Medicine: The Rural Health Programs of the Farm Security Administration* (Baltimore: Johns Hopkins University Press, 1999), see maps on pages 6 and 140.

[34] For a contemporary discussion of the Hill-Burton program in Montana, see Carl Kraenzel, "The Hospitals of Montana: Existing Facilities and Attendant Problems," *Montana Experiment Station Bulletin 437*, (October 1946), Montana Historical Society Research Center, Helena, Montana [hereafter MHSRC].

[35] Carl Kraenzel, "The Hospitals of Montana: Basis for a Coordinated Hospital-Health-Medical Care Program," *Montana Experiment Station Bulletin 456* (January 1949), MHSRC.

The Development of Hospitals in Alberta and Montana[37]

Between 1880 and 1950, there was a tremendous growth in hospitals as well as health services in Alberta and Montana. Yet, as elsewhere in North America, care of the terminally ill was not part of the medical mandate of most hospitals. As David and Rosemary Gagan have shown, the North American hospital came to be identified as a "factory whose product was health," and whose preferred patients were "those who could be cured," and those who could afford to pay for treatment and care.[38] Since hospitals in the first half of the twentieth century wanted to redress their eighteenth- and nineteenth-century reputation as death houses, it is unlikely that either chronically ill patients who might linger for long periods and then die, or terminally ill patients whose death may have been imminent, would have been welcome. Hospital owners and administrators wanted their hospitals to be seen as places where one went for care and cure, not to die.

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[36] William Aberhart and his Social Credit party ranked health care issues sixth on a list of ten major issues identified in their 1935 platform. Alberta Social Credit Party, "1935 Socred Platform," http://www.socialcredit.com/subpages_history/1935_platform.htm, accessed 8 May 2005.

[37] This chapter examines all hospitals in Montana and Alberta with the exception of the following: hospitals operated by the federal government, most of which served the Native North American populations in these two places; state or provincially operated mental institutions; veterans' institutions; and tuberculosis institutions.

[38] Gagan and Gagan, *For Patients of Moderate Means*, 42-43.

Of course, people died in hospitals, but most hospital deaths were the result of acute medical conditions, not chronic or terminal illness. For example, in 1920, a total of just over 2,400 patients were admitted to the eight municipal hospitals in Alberta. Only eighty-two patient deaths occurred from these admissions, most deaths being attributed to acute medical conditions, for example septicemia, ruptured appendix, nephritis, or heart failure. There were only three cancer deaths cited, one due to bowel cancer and two from advanced carcinoma.[39] It is impossible to know if these three cancer victims were in the hospital for end-of-life care, or whether their deaths were related to surgery or other cancer treatment, but the latter is more likely.

Because so few historians have studied the history of hospitals in the western states or western provinces of North America, there remains much to learn about the nature and purposes of hospitals in these regions.[40] Most of the focus of the historiography on hospitals has been on the urban, usually Eastern or Midwestern hospitals, with limited attention given to hospital development in the South or West.[41] Although most historians of hospitals and health care in the United States and Canada do not pursue the topic of regional difference, they do suggest that there are unique historical characteristics of hospital development in the North American West. Paul Starr, for example, argues that at the turn of the twentieth century both the American West and the South had significantly more proprietary hospitals than the East, where nondenominational hospitals dominated, or than the Midwest, which had a disproportionate number of religious hospitals. Starr claims that the Western and Southern states had fewer private philanthropists, and that this resulted in a higher percentage of profit-making institutions.[42] Clearly, attention to region leads to very different generalizations about the history of hospitals.

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[39] Alberta, DPH, *Annual Report 1920* (Edmonton: J.W. Jeffery, 1921), 23-34.

[40] A brief discussion of hospitals in the American West can be found in Duane A. Smith and Ronald C. Brown, *No One Ailing Except a Physician: Medicine in the Mining West, 1848-1919* (Boulder: University Press of Colorado, 2001), xiii, xiv, 22, 28, 98, 138.

[41] Notable exceptions include Vanessa Northington Gamble, *Making A Place for Ourselves: The Black Hospital Movement, 1920-1945* (New York: Oxford University Press, 1995); and Gagan and Gagan, *For Patients of Moderate Means.*

Up to 1950, most hospitals in Alberta and Montana were outliers from national trends. For example, in Canada the secular voluntary general hospital is generally cited as the most common form of hospital type up until at least the mid-twentieth century, and in the United States the private charitable hospital is seen as the most common. However, very few of the hospitals that opened in Alberta and Montana between 1880 and 1950 would fit either description.[43] In Alberta, even by the 1950s, only three percent of all of the hospital beds in Alberta were in secular voluntary general hospitals, while community hospitals, specifically municipal hospitals, accounted for nearly fifty percent of all hospital beds.[44] Furthermore, most of the large hospitals in Alberta's cities were operated by religious nursing orders, not charities. In Montana, religious hospitals also dominated the urban landscape, but there the Protestant order of Deaconess nursing sisters were part of the religious hospitals mix, along with the more numerous Catholic hospitals. In Alberta, hospitals owned by Protestant church organizations did exist, but in much smaller numbers.[45] Thus, most hospitals in Alberta and Montana up to 1950 were outliers from national trends.

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[42] Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 170. A proprietary hospital is one that is owned and operated by an individual or a group of individuals. See also, Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, rev. ed. (Baltimore: Johns Hopkins University Press, 1999), 20.

[43] Gagan and Gagan, *For Patients of Moderate Means*, 10; Stevens, *In Sickness and in Wealth*, 23.

[44] Boychuk, *The Making and Meaning of Hospital Policy*, 42.

Another type of institution that flourished in Alberta and Montana was the proprietary hospital, or private hospital owned by individuals. These small, home-like hospitals, most of which were opened by women, dotted the hospital landscape in both places throughout the first half of the twentieth century. Although health officials in Alberta would not approve a per diem subsidy for most private hospitals, they took other measures to support the creation of these small institutions. As early as 1921, Alberta health officials recognized the importance of these privately run hospitals, which one writer suggested "might more properly be called a nursing home, than a hospital."[46] To that end, hospital inspectors began to visit the hospitals regularly with the goal of rendering private establishments "such advice and assistance as may enable them to become self-sustaining" and in 1925 Alberta legislated such "visits" by passing the *Private Hospitals Act*.[47] In Montana, government action (or inaction) did not help or hinder the development of privately owned hospitals, and the numbers of hospitals run by women multiplied during the early decades of the twentieth century.

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[45] Overall, Protestant nursing orders were a less significant force in hospital development across North America, but in Montana the Deaconess movement had gained a strong footing by the third decade of the twentieth century. In northern Alberta, United Church missionaries operated a number of small, cottage hospitals in isolated communities. For more on the Deaconess movement in Montana, see Pierce C. Mullen, "Frontier Nursing: The Deaconess Experience in Montana, 1890-1960," in Martha L. Hildreth and Bruce T. Moran, eds., *Disease and Medical Care in the Mountain West: Essays on Region, History, and Practice* (Reno: University of Nevada Press, 1997), 82-94. For the history of one United Church sponsored hospital in Alberta, see Trudy A. Harrold, *On Highest Mission Sent: The Story of Health Care in Lamont, Alberta* (Lamont, Alberta: Aspengrove Communications, n.d).

[46] Modern readers might associate the term "nursing home" with an institution for the aged, which began operating in North America in the second half of the twentieth century. In that context, see Megan J. Davies, *Into the House of Old: A History of Residential Care in British Columbia* (Montreal: McGill-Queen's University Press,

The first and second generation of hospitals that opened in Montana and Alberta, public and private alike, bore little resemblance to some of the grand hospitals of large urban centers that have been described by hospital historians. Nor do they fit the description of the Victorian hospital, which, according to David and Rosemary Gagan, was "built for the provident poor through the generosity of the better classes and their elected representatives."[48] Grand philanthropic gestures of the sort that would build charity hospitals were rare. Institutions for the indigent sick in Alberta and Montana were built and operated by county or local governments, or by religious orders, not by the upper classes. Many hospitals were built in haste, with the earliest institutions opened to deal specifically with sudden outbreaks of infectious and contagious diseases. These isolation hospitals or "pest houses," as they were commonly referred to in Montana, were usually houses or buildings taken over by health officials to house victims of diphtheria, typhoid, or smallpox during an outbreak or epidemic.[49]

2003). In the first half of the twentieth century, a nursing home was a place where one could receive nursing care during times of illness, injury or childbirth.

[47] Alberta, DPH, *Annual Report 1921* (Edmonton: J.W. Jeffery, 1922), 14-15.

[48] Gagan and Gagan, *For Patients of Moderate Means*, 15.

[49] Roland K. Fisher, *Montana Hospitals: A Heritage in Transition* (Helena: Montana Hospital Association, 1989).

The early hospitals in Alberta and Montana were usually operated out of private residences, some of which were tiny and others large enough to have served for a while as boarding houses or other similar enterprises. If houses were not available, hospitals were opened in any number of oddly suited structures. For instance, the first hospital in Calgary, Alberta, is believed to have been an eight-bed hospital operated by a Mrs. Hoade in a small house by the Bow River. The house, whose front door was rumoured to have been riddled with bullet holes, had previously been operated as a house of ill repute.[50] When the Sisters of Charity of Our Lady of Evron arrived in Trochu, Alberta, in 1909, there were no buildings available and they had no choice but to set up hospital services in a granary.[51] The modest beginnings of these small institutions were often exemplified by the lack of necessary and important hospital equipment. For example, in keeping with the "true pioneer spirit of the West," when the Sisters of St. Francis of New York opened Sacred Heart Hospital in 1911 in Havre, Montana, the first patients admitted were required to bring along their own beds since the hospital was not yet fully furnished.[52]

Until at least the second decade of the twentieth century, hospital services were commonly offered in hotels throughout the North American West. Ironically, at the same time that some larger urban hospitals were attempting to attract affluent and middle-class patients by promoting themselves as being like luxury hotels, hospital services, especially surgery, were offered in some hotels in Montana and Alberta, few of which could have been described as luxurious by any stretch of the imagination.[53] In a study of medicine in the mining West, Duane A. Smith and Ronald C. Brown suggest that operations frequently took place in hotels, boarding houses, and private homes prior to 1920 because patients preferred not to enter hospitals, which were still viewed as places to go to die, instead of to get well.[54] Smith and Brown may be correct, but practicality may have been more of a factor than choice, since hotels were often the only site of medical and surgical care in towns or districts where there were no hospitals. In Montana, the Coleman Hotel in Glasgow, and the Prairie Inn in Chester were just two of the many hotels where patients could receive medical and surgical care during the first and second decades of the twentieth century.[55]

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[50] Jamieson, *Early Medicine in Alberta*, 33.
[51] *St. Mary's, Trochu, Alberta, Canada: 75 Years of Caring* (Trochu, Alberta: St. Mary's Hospital, 1984), 5.
[52] Fisher, *Montana Hospitals*, 75.

The passing of time did not mean that all hospitals in the region eventually caught up with the scientific hospital standards being set or met elsewhere. By the middle of the twentieth century the majority of the largest and best-supported hospitals in the region, usually in the urban centers, were thoroughly modern and equipped with state-of-the-art medical technology.[56] Meanwhile, hospitals in the more isolated areas retained their rough and rugged character. For example, in 1940, two registered nurses opened the Oilfields Hospital in an abandoned cook car in Alberta's Turner Valley, close to Calgary. The two nurses lived in a dug-out basement for the first six months that they operated their six-bed enterprise. Despite its meager beginnings, a decade later the hospital was a thriving twenty-four bed hospital.[57] In his memoir, Dr. Ron Losee recalled an appendectomy that he performed in June 1950 in the upstairs closet of the Ruby Valley Hospital in Sheridan, Montana. The female patient, Dr. Losee remembered, lay "supine on a homemade operating table, an automobile lamp shining down on her belly button."[58]

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[53] For an interesting discussion on how urban hospitals in Ontario, Canada, sought to attract and accommodate a paying clientele in the early twentieth century, see James M. Wishart, "Class Difference and the Reformation of Ontario Public Hospitals, 1900-1935: 'Make Every Effort to Satisfy the Tastes of the Well-to-Do,'" *Labour/Le Travail* 48 (2001): 27-61. For a broader analysis of hospital and medical care within the framework of consumer culture, see Nancy Tomes, "Merchants of Health: Medicine and Consumer Culture in the United States, 1900-1940," *Journal of American History* 88, no. 2 (2001): 519-548.

[54] Smith and Brown, *No One Ailing Except A Physician*, 22.

[55] Fisher, *Montana Hospitals*, 31, 59.

[56] Sue Hart, *The Call to Care, 1898-1998: Saint Vincent Hospital and Health Center* (Billings, Mont: Saint Vincent Hospital and Health Center, n.d.), 76; J. Ross Vant and Tony Cashman, *More Than A Hospital: University of Alberta Hospitals, 1906-1986* (Edmonton: University Hospitals Board, 1986), 194-246.

Rosemary Stevens argues that while urban ideology stressed that the hospital was a "center of science," rural ideology stressed that the hospital was a "center of practice."[59] Much of the hospital historiography in North America has focused on the urban model, often emphasizing the medical research and teaching components of those institutions. Since Alberta and Montana remained primarily rural in the first half of the twentieth century, it is understandable that most of the hospitals operating in the region prior to 1950 focused more directly on providing patient care than on research or teaching medical students. Few rural hospitals had the resources to support such a focus. Although several larger hospitals had nursing schools, there were no medical schools in Montana, and only the Faculty of Medicine at the University of Alberta (founded in 1913) in Alberta prior to 1950.[60]

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[57] *In the Spirit of Good Medicine: A Story of Health Care in the High River Hospital District* (Billings, Mont: Sandstone Publishing, 1990), 18.
[58] R. E. Losee, *Doc: Then and Now with a Montana Physician* (New York: Lyons and Burford, 1994), 36.
[59] Stevens, *In Sickness and in Wealth*, 131.

Since hospitals in Montana and Alberta fell more in line with the "center of practice" model rather than a "center of science" model, they remained more focused on patient care, which may have allowed them to act in some instances as surrogate caregivers for patients who had no other caregiving options. Charles Rosenberg refers to patients who lacked family caregivers as "dependent" patients. He asserts that this type of patient dependency once played a determining role in hospitalization. Focusing on the American hospital in 1900, Rosenberg claims that sickness on its own did not at that time automatically imply hospitalization, but that sickness or incapacity in people who lacked a home and family members to provide care often resulted in hospitalization.[61] Rosenberg claims that by 1920, diagnosis replaced dependency as the key to hospital admission.[62]

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[60] At that time, the University of Alberta offered the first of three years of a medical degree program that was expected to be completed at McGill University in Montreal. The outbreak of the First World War had a profound effect on faculty and students, and the program did not get back on track until 1923, with the first medical class graduating in 1927. Montana, in turn, remains one of only a handful of American states without a medical school. In addition to medical schools being very expensive to run, Montana lacks a sufficient population base. In order to have sufficient resources for clinical teaching, medical schools must be located in an area with sufficient patients. There are no formally accepted figures in this regard, but many people feel that a school should draw on a base of 750,000 - 1 million people, and at the beginning of 2004, there are fewer than a million people in all of Montana. About 30 years ago, several western states (Washington, Wyoming, Alaska, Montana and Idaho) entered into an agreement with the University of Washington Medical School to provide medical education for state residents. This has worked very well, and it has pre-empted the need for those states to try to develop their own school.

[61] Rosenberg, *The Care of Strangers*, 337-338.

[62] Charles Rosenberg, "Community and Communities: The Evolution of the American Hospital" in *The American General Hospital: Communities and Social Contexts*, Diane E. Long and Janet Golden, eds. (Ithaca: Cornell University Press, 1989), 5.

Later development patterns, limited health care options, and demographic characteristics meant that hospitals in Alberta and Montana continued to act as multi-purpose institutions well into the twentieth century, serving a clientele of people who were admitted for diagnosis or treatment or because they had no place else to go for caregiving. In particular, the highly transient and numerically dominant male populations in Montana and Alberta meant that many people lacked family members who lived close enough to provide care during times of illness. Thus, although hospital administrators might have preferred otherwise, some hospitals expected and were expected to provide surrogate caregiving services.

The importance of the hospital as the locus for surrogate care was patently obvious to health officials in territorial Alberta. Through the per diem subsidy program, the Alberta government provided hospital care in non-privately owned hospitals for individuals who lacked caregiving alternatives. In the annual report of the Department of Agriculture in 1898, a writer remarked on the "peculiarly appropriate field for hospital work in the North-West Territories." The reason, he claimed, was that a large proportion of the settlers were unmarried men who often lived alone, miles away from "the nearest charitably inclined neighbour who could look after them in time of sickness or accident."[63] Although not explicitly stated, it is reasonable to assume that most charitably inclined neighbours in the territory, in this inspector's opinion, would be female. In Montana and Alberta, hospital owners and administrators, many of whom were also

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[63] North-West Territories, DOA, *Annual Report 1898* (Regina: John A. Reid, 1899), 89.

female, were responsible for acts of charity, both small and large, toward more unfortunate segments of society. The dying may have been one such segment.

The surrogate caregiving functions of hospitals in Montana and Alberta were of notable significance to the care of the terminally ill. Despite a focus on acute care, some hospitals in Montana and Alberta may have been open to taking on the role of caregiver for terminally ill people who lacked other caregiving options, as part of a broader social or spiritual mandate, rather than a medical one.

Catholic Hospitals

Hospitals owned and administered by Catholic nursing orders were of particular importance to the care of the dying in Montana and Alberta. Often the first hospitals to open in the North American West, Catholic hospitals proved to be the most enduring.[64] In 1925, such hospitals accounted for 30 percent of all hospital beds in Alberta, and nearly 40 percent of all hospitals in Montana.[65] By the 1950s, hospitals operated by Catholic nuns accounted for nearly 35 percent of all hospital beds in Alberta, and 50 percent of all hospital beds in Montana.[66]

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[64] Barbra Mann Wall, "Unlikely Entrepreneurs: Nuns, Nursing, and Hospital Developments in the West and Midwest, 1895-1915" (PhD Dissertation, University of Notre Dame, 2000).

[65] Author's calculations for Montana and Alberta from American Medical Association, *American Medical Directory* (Chicago: American Medical Association, 1925), 953-954, 1731.

[66] Figure for Alberta is from Boychuk, *The Making and Meaning of Hospital Policy*, 46. Montana figure is from author's calculations from American Medical Association, *American Medical Directory* (Chicago: American Medical Association, 1950), 1185-1186.

The relationship of Catholic nurses to care of the dying has been explored in some detail by Barbra Mann Wall who claims that the nuns' desire to save souls before death was an important reason behind their desire to attend the sick. As places where extreme and critical health crises arose, hospitals were sites of important sacramental power.[67] Nuns tended to the immediate physical needs of their sick patients, but they also prepared souls for eternity. Todd L. Savitt and Janice Willms observe that in the late nineteenth century, the Sisters of Providence, owners and operators of a hospital in Missoula, Montana, sometimes seemed as concerned with converting patients as they were with caring for them.[68]

Religious hospitals walked a fine line while trying to fulfill their dual mandates of providing physical and spiritual care to patients. Nuns may have been willing to care for the dying, but they also wanted their hospitals to be successful business ventures and were careful not to promote an image of their hospitals as centers for dying.[69] Although Catholic nuns in Alberta's hospitals welcomed all types of patients, including non-Catholics, Dr. George A. Kennedy, the Inspector of Hospitals for the Province of Alberta, had rather different ideas about the type of patients who were "fit subjects for hospital treatment." Fit subjects appear to have been those patients who required medical attention and were admitted to hospital on the order of a physician, not patients who required surrogate caregiving services.[70]

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[67] Wall, "Unlikely Entrepreneurs," 9.

[68] Todd L. Savitt and Janice Willms, "'Sisters' Hospital: The Sisters of Providence and St. Patrick Hospital, Missoula, Montana, 1873-1890," *Montana* 53, no. 1 (2003): 35-36.

[69] Savitt and Willms, "'Sisters' Hospital," 285.

[70] North-West Territories, DOA, *Annual Report 1898*, p. 94.

Unlike Alberta hospitals that were careful only to admit patients whose presence they could justify in order to receive the per diem grant, religious hospitals appeared to accept all patients. For instance, when Dr. Kennedy visited the Grey Nuns' Holy Cross hospital in Calgary in August 1901, he found that one of the ten patients did not need hospital treatment. Mrs. Ferland, who had been in the hospital since April, had been admitted for "la grippe," but in Dr. Kennedy's opinion, she merely suffered from old age. He advised the hospital administrator that Mrs. Ferland was not a proper subject for hospital treatment and suggested "the advisability of having her friends look after her."[71] This example points out that there was a difference between what government officials thought hospitals were for versus what hospital administrators believed. Or it might show that religious hospitals were less dependent on government subsidies. Judging from his comments, Dr. Kennedy apparently understood that Mrs. Ferland did need somebody to "look after her." It is also apparent that Mrs. Ferland had no family, since Dr. Kennedy did not suggest that family members look her after. It would seem that Dr. Kennedy objected to paying a per diem grant to subsidize the care of an aged woman with minor medical complaints. However, from the nuns' perspective, their hospital was more than just an institution that provided medical care. Like other Catholic nursing sisters in the West, nuns in Alberta believed that the need for nursing care was justification for hospitalization.[72]

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[71] North-West Territories, DOA, *Annual Report 1901* (Regina: John A. Reid, 1902), 144.

[72] Pauline Paul, "A History of the Edmonton General Hospital: 1895-1970" (PhD Dissertation, University of Alberta, 1997), 72. In her study of nursing nuns in the West and Midwest, Wall discusses the conflicts between physicians and nuns over hospital admissions and finds that nuns regularly made decisions to admit patients against physicians' wishes. Wall, "Unlikely Entrepreneurs," 332.

Although Wall's advice to "discard the notion of hospitals as inevitably and uniquely medical" is instructive, it is also important to acknowledge that nursing sisters provided more than spiritual care to their dying patients. [73] They were, after all, nurses. Prescriptive nursing literature written by and for nuns regularly referred to physical as well as spiritual care of the dying.[74] The following excerpt from a poster entitled "Duties of a Nurse to Herself" that hung in the Misercordia Hospital in Edmonton, Alberta, in February 1907, highlights the commitment that nuns had to the provision of compassionate physical care to the dying.[75]

> Dying Patients
>
> When it is clear that your patient is dying, your quiet self-possession and unobtrusive sympathy will be of the first importance. Do all in your power for your charge; even if [he or she is] unconscious there are numberless things to do for the dying person. Moisten the lips frequently, wipe away the sweat gathering on face and hands. Keep the feet as warm as possible. Fan the forehead. Allow the friends of the patient to do anything that can add to his comfort. The doctor must be notified immediately when death occurs.

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[73] Wall, "Unlikely Entrepreneurs," 482.

[74] Sister Mary Berenice Beck, *Handmaid of the Divine Physician: The Religious Care of the Sick and Dying*, rev. ed. (Milwaukee: Bruce Publishing Company, n.d.).

[75] John Gilpin, *The Misercordia Hospital: 85 Years of Service in Edmonton* (Edmonton: Plains Publishing Inc, 1986), 54.

This excerpt reinforces the idea that even as death approached, there was always something to be done for the dying. The excerpt also confirms that nurses, not doctors, attended dying patients since the poster instructs the nursing sisters that the doctor needs to be called after the patient has died. This further attests to the likelihood that regardless of where terminal care took place, women provided care to the dying.

Female Proprietorships

The development of female proprietorships or private hospitals in the first half of the twentieth century provides another indication of women's influence in the provision of health care. Women who opened private hospitals in Montana and Alberta exhibited the same degree of control over their institutions as Catholic nuns. As owners, they made decisions about the types of admissions they would accept in their hospitals, the length of patient stays, and the costs of nursing care. Although it was not their express purpose, these small hospitals sometimes provided surrogate care to dying patients.

The female proprietor of the small general hospital is a character whose story is long overdue. The history behind hospitals owned, operated and controlled by female proprietors emerges as one of the most intriguing aspects of hospital history in Montana and Alberta, and offers some important insights into the practicality, or not, of admitting dying patients to small hospitals.

Although female proprietorships appear to have existed in large numbers in the North American West and elsewhere, they have never received more than a passing comment by a few hospital historians.[76] Paul Starr briefly mentions that in the late nineteenth century women operated "medical boarding houses" that provided a mixture of hotel services and nursing and were more convenient for physicians who lost time by having to make house calls.[77] Other historians have referred to female-operated hospitals in more disparaging tones. For example, in his survey of the early history of hospitals in Canada, G. Harvey Agnew derides these private hospitals for providing "little more than room and board with virtually no medical supervision."[78] In *Early Medicine in Alberta: The First Seventy-Five Years*, Heber C. Jamieson acknowledges the existence of female proprietorships in a rather off-hand manner when he laments that the first hospitals in Alberta were little better than rooming houses run by unqualified nurses. He asserts that, while many of these "nurses" (his quotation marks) had little medical experience, their common attributes were "goodwill, charity, and sympathy." He further claims that the small houses that passed for hospitals in various centers were "taken over" when the pioneer medical men arrived in the province.[79]

Although Starr, Agnew and Jamieson note the existence of female proprietorships, they fail to recognize the historical significance of these hospitals.

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[76] A book by James Clark Fifield, published in 1933 in cooperation with the American Medical Association, provides an inventory of hospitals in Canada and the United States, by state and province. The inventory suggests that female proprietorships existed throughout North America in that period. James Clark Fifield, *American and Canadian Hospitals: A Reference Book of Historical, Statistical and Other Information on the Hospitals and Allied Institutions of the United States and Possessions and the Dominion of Canada* (Minneapolis: Midwest Publishing Co., 1933).

[77] Starr, *The Social Transformation of American Medicine*, 157.

[78] G. Harvey Agnew, *Canadian Hospitals, 1920-1970: A Dramatic Half Century* (Toronto: University of Toronto Press, 1974), 5.

[79] Jamieson, *Early Medicine in Alberta*, 88-89.

Despite their small size, and regardless of whether the women operating them had professional nursing designations, these institutions were much more than mere boarding houses for the sick. The availability of these small hospitals meant that patients had access to critically important surgical and medical services, as well as nursing services, usually in communities where no other hospital options existed. This may explain why some women proprietors ended up providing terminal care. Contrary to Jamieson's claim, many female hospital owners had completed formal nursing training. For example, out of nine female proprietorships operating in Montana in 1931, five were owned by registered nurses.[80] For other women running hospitals in Alberta and Montana, informal experience as midwives or practical nurses may have been as valuable a prerequisite for running a hospital as professional nursing credentials.

Regional variation shaped the history of female proprietorships. Rather than being a nineteenth-century phenomenon, as Starr suggests, female proprietorships only began to emerge in Alberta and Montana after the turn of the twentieth century, and they remained a force in small-town Montana and Alberta throughout the first half of the century. For example, by 1922, there were fifty-nine private hospitals in Alberta, and women ran all of them. Graduate nurses were in charge of twenty-four of them, with the remainder operated by certified midwives or practical nurses.[81] Although a comprehensive inventory of female proprietorships in Montana still needs to be undertaken, evidence shows that there were dozens in operation throughout the first half of the twentieth century. When the Hospital Survey Committee compiled its inventory of Montana hospitals in 1945, it included twenty-two small "below standard institutions" in the list of sixty-five hospitals then operating in Montana.[82] From other research, primarily local histories and amateur hospital histories, it is apparent that the majority of these small hospitals were female proprietorships. The fact that so many private hospitals still operated in Alberta and Montana as late as the 1940s underlies their continuing importance in this region of the North American West.

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[80] Author's calculations drawn from Fifield, *American and Canadian Hospitals*, 688-697.
[81] Alberta, DPH, *Annual Report 1933* (Edmonton: W.D. McLean, 1935), 29.

Physicians, as well as patients, depended upon the availability of female proprietorships in small town Montana and Alberta. Contrary to Jamieson's claims, physicians did not take over small hospitals run by women, but rather women often took over small hospitals run by doctors. Sources suggest that in the first several decades of the twentieth century, the number of male proprietorships in Montana fell as the number of female proprietorships rose. In Montana in 1912, there were nineteen male proprietorships, most of them owned and operated by male physicians, and only three female proprietorships. By 1933, there were six male proprietorships and nine female proprietorships, and by 1936 women owned and operated five private hospitals in the state, and men owned and operated only two. Finally, by 1950, there were only two sole proprietorships left operating in Montana, both of them owned by women.[83]

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[82] Kraenzel, "The Hospitals of Montana," 11.

[83] American Medical Association, *American Medical Directory* 1912, p. 71; Fifield, *American and Canadian Hospitals*, 688-697; American Medical Association, *American Medical Directory* 1936, p. 979; American Medical Association, *American Medical Directory* 1950, pp. 1185-1186.

Alberta never did have many small hospitals owned by male physicians. There, and in Montana after the 1910s, the arrival of a trained physician in a community that lacked hospital facilities often prompted the opening of the small, female-operated hospital. In fact, in 1934, when a Dr. Olson arrived in Coutts, Alberta, he paid scant attention to the national border when he convinced two women to open the "Border Hospital" to serve the residents of Coutts, as well as the residents of Sweetgrass, Montana, the town immediately south of them, on the other side of the border crossing. Dr. Olson cooperated with the two female proprietoresses of the Border Hospital for three years, when the closing of the hospital coincided with the closure of a large oil refinery in Coutts.[84]

Few records generated by the women or their hospitals have survived, but newspaper ads and articles from the period, as well as provincial hospital inventories and government records, suggest that the women who ran these private hospitals did provide nursing care at both ends of life. These institutions had particular implications for care of the dying. [85] People who were critically ill often sought care in these small institutions. For example, although space restrictions would have made the long-term care of significant numbers of terminally ill patients difficult, hospital inspection reports in Alberta show that cancer patients were operated on and cared for in these hospitals, and a few even died there.[86]

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[84] Women's Institute of Coutts, Alberta, *The History of the Border Country of Coutts*, 1890-1965 (Lethbridge: Southern Printing Co., 1965).

[85] Laurel Halladay, "'We'll See You Next Year': Maternity Homes in Southern Saskatchewan in the First Half of the Twentieth Century" (Masters Thesis, Carleton University, 1996), 65.

[86] Alberta, DPH, *Annual Report*, 1920, pp. 23-34.

The early history of female proprietorships and other small hospitals in Montana and Alberta is best characterized as fluid and changing. Hospitals opened, changed hands, burned or closed down, and then opened under new names and new management. Once established, hospital services became essential services, and communities appear to have adapted to the ongoing changes in hospital ownership or management. Such was the case in Livingston, Montana. After Dr. Byron Pampel arrived in Livingston in 1899 he practiced for several years without access to a hospital before he opened his own hospital in 1908. He operated the hospital with the assistance of Mrs. Anna Morgan as Matron for only one year.[87] According to entries in his daybook, beginning in 1910, Dr. Pampel began to deliver babies and see patients at "Mrs. Rae's Hospital."[88] In 1921, he started treating patients at "Mrs. Robinson's hospital," and during 1928 he started to record the names and ailments of patients he visited at the "Lott Hospital." At first glance one might assume that these hospitals were maternity hospitals, since Dr. Pampel did attend births in them. However, he also performed appendectomies, amputations, and other operations, especially at Miss Lott's and Mrs. Robinson's hospitals, over the many decades that he practiced in Livingston.[89]

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[87] Dr. Byron Pampel, Physician's Daybooks, 1899-1938, Byron Lee Pampel Records, MHSRC.

[88] Mrs. Elizabeth Rae operated a maternity hospital in Livingston from approximately 1894 to 1927. "Mrs. Elizabeth Rae Passes Away Friday," *Park County News*, 17 June 1927.

[89] If a patient underwent an appendectomy, it might be announced under the "Here and There" column of the weekly newspaper. Other notices were less explicit about a patient's exact medical condition. For instance, in August 1927 Mrs. Charles Hippely, who was "seriously ill at the Lott hospital" was reported as showing a "slight improvement." On the same day, Mrs. Miles Mifield underwent "a major operation at the Lott Hospital" but was "doing as well as can be expected." *Park County News*, 12 August 1937.

As the community grew, so too did the need for more hospital services. Both Mrs. Robinson and Miss Lott steadily expanded their hospital operations over the years. In 1933 the seven-bed Robinson Hospital was a general hospital with services in medicine, surgery, diabetes, gynecology, obstetrics, and pediatrics.[90] Attending staff at the time numbered four, with one graduate nurse regularly employed. In the late 1930s, overcrowding caused Mrs. Robinson to move the hospital to larger quarters. The hospital remained in operation until 1942, when Mrs. Robinson closed the hospital and returned to private nursing. The Robinson hospital may have had trouble competing with the larger and busier Lott Hospital. Miss Lott opened her hospital in 1928 and was so successful that within a year she had to move the hospital to a larger building. Her hospital, according to a newspaper article, had for many months been badly crowded and the need for more room had become "urgent."[91] The house that Miss Lott purchased was an 11,000 square foot, four-story building with over 30 rooms. Miss Lott owned and operated the Lott Hospital until 1947, when she sold it to a few local doctors. Later descriptions claimed that Miss Lott, who was apparently too kind-hearted to ever send anyone away, was forced to sell her hospital due to financial hardship.[92] Kind-hearted she may have been, but Miss Lott was also emphatic about who was in control of the Lott Hospital over her twenty-year tenure. Her ad in the local newspaper listed the name, address and phone number of the hospital, followed by her claim, "under my personal supervision."[93]

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[90] Fifield, *American and Canadian Hospitals*, 694.
[91] "Shelley Home for Hospital: Lott Hospital to Move to New Quarters Immediately," *Park County News*, 13 June 1929.
[92] *History of Park County, Montana* (n.p.: Taylor Publishing Co., 1985), 91.

Although private hospitals operated to the benefit of the community, the women who ran them opened them in order to make a living. For instance, when Ellen Robinson opened the Robinson Hospital in the early 1920s, she was a widow who needed to support her two sons [94] Mrs. Robinson's provision of hospital services appears to have earned her respect and affection within Livingston's medical community. That the medical men likely held her in relatively high esteem was apparent at her funeral in March 1952, when five local physicians, including Byron Pampel, served as honorary pallbearers at her large funeral.[95]

A spirit of mutual dependence, not conflict, characterized the relationship between female hospital owners and medical professionals.[96] Female owners ran the hospitals, but they conducted their businesses in close association with local physicians and surgeons. Good relations with doctors and surgeons were imperative. Income from referred patients and surgical procedures was the bread and butter of the hospital operations. Likewise, doctors depended on the convenience of having hospital accommodation and nursing services provided by the female proprietors. The availability of the small private hospitals meant that doctors could dedicate themselves more completely to providing medical care, without the worries of managing a hospital. The relationships between physicians and the operators of these private hospitals, most of whom were nurses, were clearly interdependent, if not egalitarian

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[93] *Park County News*, 6 January 1928

[94] Ellen Minot Robinson moved to Livingston in 1888, earning the distinction of being the first graduate nurse to practice her profession in Park County. She married in 1907 and moved to Seattle, but returned to Livingston three years later as a widow with two young sons. "Mrs. Ellen Robinson, First Nurse in County, Passes," *Park County News*, 13 March, 1952.

[95] Obituary, *Park County News*, 13 March, 1952.

[96] Joan Lynaugh has identified the egalitarian relationship between nurses and doctors in the early twentieth century as an intriguing area for further study. As she shows in her study of community hospitals in Kansas City, the "social, economic, and educational gap between a trained nurse and a physician in 1905 probably was quite narrow. Physicians had not yet gained the level of control over hospitals that they would eventually come to have. Joan Lynaugh, *The Community Hospitals of Kansas City, Missouri 1870-1915* (New York and London: Garland Publishing, 1989), 188.

Over most of the second quarter of the twentieth century, the Lott and Robinson hospitals provided vital medical service to the people of Livingston, with the focus of most of the hospital work on maternity and acute medical care, especially surgery. It is hard to tell from the newspaper reports how many terminally ill patients were admitted to the Robinson or Lott hospitals. As suggested earlier, space restrictions might have made the admission of terminal patients less likely, or at least less feasible financially. For instance, when the Robinson hospital had only seven rooms, it would have been financially detrimental for Mrs. Robinson to admit chronically or terminally ill patients for long periods of time, since those patients would take up space that more profitable surgical patients might occupy. In 1931, daily rates at the Robinson Hospital were $4.00 for a private room, but operating room fees earned Mrs. Robinson between $5.00 and $10.00 per surgery. A steady supply of surgical patients, especially those admitted for minor surgeries, would ensure Mrs. Robinson a steady income, income that would not accrue from terminally ill patients paying $4.00 per day for nursing care.[97] Still, as suggested by the endurance of their reputations as generous community caregivers, Miss

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[97] Fifield, *American and Canadian Hospitals*, 694.

Lott and Mrs. Robinson may not have turned away a dying patient if that patient had no other caregiving alternative. The man who managed the Lott Hospital after Miss Lott sold it remembered that Miss Lott had "never asked if a patient could pay for treatment." As this man observed, Miss Lott was "one of the most lovable persons you ever saw, but you can't run a hospital on love." A nurse who worked at the Lott Hospital recalled that Miss Lott "finally went broke just being so good to people."[98]

Female proprietors were equally instrumental in their provision of hospital services in Alberta. Some women made a good living as hospital owners in this prairie province, while others struggled to make ends meet. As in Montana, the ever-growing demand for hospital services resulted in the expansion of hospital services by female owners. Mrs. Maria Elizabeth Van Haarlem of Lethbridge entered the hospital business in 1909 when she set aside two rooms in her rented house to receive patients. Twenty years later, she sold her twenty-seven-room hospital, complete with an operating room, physiotherapy room, and a modern laboratory, to the Sisters of St. Martha of Antigonish.[99] Other women were unable to meet the increasing demands on their small institutions. In Claresholm, Alberta, Mrs. Taylor tried to keep up with an increasingly busy hospital in small town southern Alberta until early December 1927. Mrs. Taylor had owned her hospital for less than two years when a newspaper article reported that she had decided to close it effective March 1928. Mrs. Taylor claimed that the demands upon the institution had outgrown the accommodation and that she was "not prepared" to make the financial investment to expand the facilities. The patient caseload was constantly growing. In 1927, 385 patients were admitted to the hospital—131 more patients than the previous year.

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[98] Fisher, *Montana Hospitals*, 87.

[99] A. Johnston, *Lethbridge: Its Medical Doctors, Dentists, Drug Stores* (Lethbridge, Alta.: Lethbridge Historical Society, 1991), 10.

Although most businesses would have welcomed more clients, Mrs. Taylor claimed that for a privately owned hospital, the increasing patient demand had a debilitating effect. All the more so, she claimed, since the indigent patient load had been particularly heavy during 1927.[100] For instance, a death notice printed on December 16 in the *Review-Advertiser* reported that Charles A. Swanson, who had been a patient in the Claresholm hospital for two months, had died.[101] It appeared that Mr. Swanson, a farmer from the district, died from a cancerous condition of the liver. He was estranged from his wife and daughter, who resided in North Dakota but who had arrived in Claresholm just a few hours before his death.[102] Given the negative financial impact of drought and grasshoppers on farmers in the district during 1927, there is a good likelihood that Mr. Swanson was one of the indigent patients whose care over a two-month period pushed Mrs. Taylor to decide to close the hospital. That Mr. Swanson was on his own and did not have a female caregiver at home was likely the reason that he had been admitted to Mrs. Taylor's hospital in the first place.

In the end, one cannot be certain of the precise role that small female-owned hospitals played in the care of the dying in Montana and Alberta. Since the cost for one day's care in these hospitals was likely greater than most families could afford, several weeks or months of terminal care would have been out of the question. Even if they could afford hospital care, what would the benefit be to patients or families? Small hospitals such as these were not very different from family homes.[103] If a dying person and family members had resources, they were more likely to employ a private duty nurse, if one was available, who could provide care in the home, rather than transfer care to the hospital. Further research into these unique hospitals must be undertaken in order to fully understand the nature of the care that they provided, as well as their role in the provision of terminal care.

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[100] "The Hospital Situation," *Claresholm Local Press*, 9 December 1927.

[101] "Claresholm Local News," *Review-Advertiser*, 16 December 1927.

[102] A second obituary on the same day in the *Claresholm Local Press* provided more details about Mr. Swanson's death. "Hospital Notes," *Claresholm Local Press*, 16 December 1927.

Conclusion

The history of hospitals in Montana and Alberta shows that they retained their role as a substitute home even as they worked to become centers for the treatment of acute episodic care. In Joan Lynaugh's study of Kansas City hospitals, she argues that by 1920 "the focus of patient care in North American hospitals shifted slowly from shelter and surrogate caretaker toward medical diagnosis and active surgical intervention."[104] The key word is "slowly," and in Alberta and Montana prior to 1950, that shift was never complete.

Although there were some differences in how health and hospital services developed in Montana and Alberta between 1880 and 1950, the results for the terminally ill in both places were essentially the same. Care of the dying was seldom, if ever, the focus of health care work or hospitals. Although hospitals in Montana and Alberta did not intend to provide care for dying people, some people who were terminally ill did receive end-of-life care in some hospitals, as the story of Charles Swanson, who died of cancer in Mrs. Taylor's hospital in 1927, suggests. In such instances, the availability of a hospital, and the attitudes of its administrators, dictated the response to the dying. In the following chapter, a closer look at how Albertans and Montanans dealt with terminally ill tuberculosis and cancer patients affords a better view of terminal care in hospital, and the circumstances that led to it.

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[103] Stevens, *In Sickness and In Wealth*, 35.
[104] Lynaugh, *The Community Hospitals of Kansas City, Missouri*, 67.

CHAPTER THREE

Drawing Distinctions Between the Curable and the Incurable with Tuberculosis and Cancer

Between 1880 and 1950, doctors identified some health problems as curable and some as incurable. One way to locate care of the dying in Alberta and Montana is to examine programs for the "incurables." In this time period, both physicians and patients understood that cancer and tuberculosis were often fatal diseases. The survival rates for cancer victims in both Canada and the United States were the same throughout this period, and they were abysmal. As late as the 1930s, only one in five people diagnosed with cancer survived for five years. By the 1940s there was only a small improvement: one in four cancer patients reached the five-year mark.[1] Although the prognosis for tuberculosis sufferers improved dramatically with the discovery of antibiotics in the 1940s, the high death rates—in the decades before that discovery—mean that it too serves as a useful model for an examination of terminal care.[2]

As elsewhere, hospital services related to tuberculosis and cancer were aimed at eradicating or treating the disease, not at easing the passage of those suffering in the terminal stages. Thus, even administrators of tuberculosis and cancer programs were reluctant to admit terminally ill patients. Furthermore, when doctors determined that curative efforts had failed, administrators made every effort to send dying cancer and tuberculosis patients home. However, such efforts were not always successful. At their own insistence or because there were simply no other options available, some people who could not be cured spent their dying days in hospitals and sanitariums.[3]

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[1] Sherwin B. Nuland, *How We Die: Reflections on Life's Final Chapter* (New York: Vintage Books, 1995), 220.

[2] In the United States, the death rate from tuberculosis in 1930 was 70 per 100,000 and in 1945 it had fallen to 40 per 100,000. Sheila M. Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (New York: Basic Books, 1994), 248. The death rate from tuberculosis in Canada was nearly the same: 79 in 1930 and 47 in 1945. Katherine McCuaig, *The Weariness, the Fever, and the Fret: The Campaign Against Tuberculosis in Canada, 1900-1950* (Montreal: McGill-Queen's University Press, 1999), 292.

The lack of kin resources was a key determinant of where terminal care took place for people diagnosed with cancer and tuberculosis. Evidence suggests that, lacking other caregiving alternatives, single, widowed and divorced males who moved to Montana or Alberta to mine, farm, ranch or work for wages sometimes drew their last breath in hospitals whose purpose was to provide specialized care, but not terminal care. In this respect, institutionalized care of the dying mirrored the situation facing the aged and the mentally ill. As Megan Davies has shown, the gender imbalance in British Columbia society translated into a lack of family members to provide care to the elderly, in particular elderly men, throughout the first half of the twentieth century.[4] In a study of insanity in California, Richard Fox claims that recently arrived immigrants, and unmarried men in particular, were especially vulnerable to institutionalization between

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[3] Sheila Rothman explains that although many people use the terms "sanitarium" and "sanatorium" interchangeably, they had different meanings in the nineteenth century, with the former referring to a "health resort" and the latter a medical institution established for the express purpose of treating tuberculosis. Rothman, *Living in the Shadow of Death*, 157. In my research, the different usage of the two terms was national, with "sanitarium" employed in Montana and "sanatorium" the usual term used in Alberta. In both cases these institutions were medical ones, built to treat tuberculosis patients.

[4] Megan J. Davies, *Into the House of Old: A History of Residential Care in British Columbia* (Montreal: McGill-Queen's University Press, 2003), 16-17, 21.

1870 and 1930.[5] Finally, Cheryl Warsh has also identified lack of kin resources among young immigrants as a salient factor in asylum admission in London, Ontario, during the late nineteenth century.[6] In Alberta and Montana, the large number of male migrants from other places in North America and the many single, male European and Asian immigrants meant that some tuberculosis and cancer programs were forced to provide care to those people who had nowhere else to go.

Tuberculosis

In Alberta and Montana, exploring the care of persons suffering from terminal tuberculosis draws attention to two particular groups of men: miners and veterans. In Montana, the tuberculosis problem appeared to be greatest among the male mining population.[7] In Alberta, although mining was an important and visible industry, veterans were the major focus of public health concerns related to tuberculosis.[8] Veterans from the First World War, some of whom were Albertans returning home and others of whom were from elsewhere in Canada, seemed convinced that Alberta offered hopes of cure unavailable in other places.

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[5] Richard Fox, *So Far Disordered in Mind: Insanity in California, 1870-1930* (Berkeley: University of California Press, 1978), 117-121.

[6] Cheryl Warsh, "In Charge of the Loons': A Portrait of the London, Ontario Asylum for the Insane in the Nineteenth Century," *Ontario History* 74 (1982): 138-84.

[7] Although the topic of tuberculosis has not been addressed in any of the surveys of Montana history, the rise of industrial mining has received a lot of attention. See K. Ross Toole, *Twentieth-Century Montana: A State of Extemes* (Norman: University of Oklahoma Press, 1972); Michael P.Malone, Richard B. Roeder and William L Lang, *Montana: A History of Two Centuries*, rev. ed. (Seattle: University of Washington Press, 2003), 185-192.

[8] Alberta had more combat veterans than Montana because Canada entered the First World War in August 1914 and the USA in April 1917. Enlistments were particularly high in Western Canada.

Tuberculosis had gained a lot of public health attention in the North American West by the late nineteenth century. As Sheila Rothman demonstrates in her brilliant work on the social history of tuberculosis, the migration of "health seekers" was an integral factor in the history of the westward movement during the second half of the nineteenth century. As Rothman and other historians have shown, scores of men and women suffering from the symptoms of consumption, as tuberculosis was called in the nineteenth century, migrated to the western United States. Colorado, southern California, Texas, New Mexico and Arizona received the largest number of health seekers. Colorado was the only Rocky Mountain state to receive a substantial influx of consumptives. By 1900, one-third of Colorado settlers had migrated seeking improved health, most of them settling in Denver and Colorado Springs.[9]

Although tuberculosis became a concern in Montana, health seekers were not significant in the settlement of the state. Connie Staudohar reveals that by the turn of the century, Montana had neither experienced nor desired an influx.[10] In its first annual report of 1902 the newly formed State Board of Health referred to the consumptives in other western states as having already proven themselves to be a "menace and a detriment." Some localities even considered legislating against the influx of tubercular persons, although that measure never came to fruition.[11]

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[9] Rothman, *Living in the Shadow of Death*, 132. For further discussions of health seekers in the American west and southwest, see Jeanne Abrams, *Blazing the Tuberculosis Trail: The Religio-Ethnic Role of Four Sanatoria in Early Denver* (Denver: Colorado Historical Society, 1990); Billy M. Jones, *Health-Seekers in the Southwest, 1817-1900* (Norman: University of Oklahoma Press, 1967).

[10] Connie Staudohar, " ' Food, Rest, and Happyness': Limitations and Possibilities in the Early Treatment of Tuberculosis in Montana Part I," *Montana* 47, no. 4 (1997): 51.

Unlike the situation in Montana, in Alberta, as Janice P. Dickin McGinnis notes, "shameless boosterism" was responsible for an influx of tubercular patients into the southern part of the province during the final few years of the nineteenth century. In 1895, the City of Calgary, hoping to attract federal money, drew up a proposal entitled, *Calgary, The Denver of Canada: Its Adaptability as a Health Resort and as a Site for the Dominion Sanatorium for the Treatment of Consumption.*[12] That effort did not succeed, but another widely circulated pamphlet entitled *Calgary, Alberta as a Home for Consumptives* did draw tuberculosis patients from outside of the territory to Calgary and the surrounding foothills area.[13] Like civic officials in Denver, Calgary officials hoped that consumptives from other parts of Canada would migrate to southern Alberta, be cured, and then take up agricultural pursuits to help settle the region.

Unfortunately, lamented the provincial medical officer in 1901, the advertisement worked. In 1901, Dr. George A. Kennedy, the provincial medical officer, denounced the practice of physicians in the eastern provinces who sent their tubercular patients west to seek the health benefits of pure air, elevation, and dryness.[14] Dr. Kennedy did not dispute the salubrity of Alberta's climate but the facts were, he claimed, that when tubercular people arrived in Alberta there were no facilities to provide them with the care they were promised. Rather, they were looked upon as a group of "pariahs," given that the Calgary General Hospital, overwhelmed by the numbers of new cases, had closed its doors against tubercular patients. Unless patients concealed their condition, even hotels and boarding houses would not admit them. According to Dr. Kennedy, there were cases of people with far advanced tuberculosis who had traveled to southern Alberta for treatment and who, after being turned away from hospitals, hotels and boarding houses, ended up "dying under the most distressing circumstances."[15]

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[11] Montana, State Board of Health [hereafter SBH] *First Biennial Report 1901-1902* (Helena: Independent Publishing, 1902), 17.

[12] City of Calgary, *Calgary, The Denver of Canada: Its Adaptability as a Health Resort and as a Site for the Dominion Sanatorium for the Treatment of Consumption* (Calgary: Calgary Herald Printing, 1895), as cited in Janice P. Dickin McGinnis, "The White Plague in Calgary: Sanatorium Care in Southern Alberta," *Alberta History* 28, no. 4 (1980), 2.

[13] City of Calgary, *Calgary, Alberta as a Home for Consumptives* (Calgary: n.p., 1895).

Although Calgary officials were largely to blame for the situation, Albertans clearly expected the Dominion government to provide the solution. Anti-Eastern sentiment appeared to be in play, somewhat surprisingly given that such a large portion of Albertans were recent arrivals from the East. Dr. Kennedy called upon the Dominion government to build a sanatorium, claiming that ninety-nine percent of tuberculosis patients were "bona fide residents of Eastern Canada" and that they had "no claim whatever" on the services that had been set up and supported by voluntary subscribers who had worked hard to settle the area and who had, with very little capital available, built the hospitals. Hospitals may have been established by the people and for the people, but the people who were entitled to hospital care, at least in Dr. Kennedy's opinion, were defined by the length of their residency, and not by the fact of their illness.

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[14] It would be interesting to learn why Dr. Kennedy did not feel the need to admonish the Calgary officials who drew the patients to Calgary in the first place, but the answer to that is not clear.

[15] North-West Territories, Department of Agriculture (hereafter DOA) *Annual Report 1901* (Regina: John A. Reid, 1902), 143.

By 1914, according to Dr. Kennedy, the need for sanatoria and hospitals to treat tubercular patients in Alberta remained "insistent."[16] The onset of the First World War, specifically the poor physical condition of military recruits, provided the imperative to address the problem. In December 1920, the Central Alberta Sanatorium was opened at Robertson, a joint venture of the Dominion and Provincial governments.[17] The sanatorium cost $500,000 and had 175 beds, 100 reserved for soldier patients and the remaining seventy-five for civilian cases. The costs for soldier care were the responsibility of the Dominion government, while the province paid for civilians. Based on the model of Dr. E. L. Trudeaus's Saranac Lake Sanitarium in New York State, tuberculosis institutions were more typically "health spas" than hospitals.[18] Thus, they were built for those whose health could be improved and like hospitals, they were not intended for those who were going to die.

From its inception, the goal of the sanatorium in Alberta was to treat only those tuberculosis patients deemed "curable." The provincial medical officer of health advised that it was "not desirable" to place curable and hopeless cases in the same institution, as the presence of advanced tuberculosis had an "unfavorable influence" upon other cases. Rather, he continued, other hospitals in the province, which were in receipt of the per diem patient grant, were expected to provide care to cases of advanced tuberculosis.[19] However, most of the community hospitals throughout the province did not have the necessary facilities to treat tuberculosis patients, namely a separate ward, wing, or building to house the tuberculosis sufferers. As discussed in the previous chapter, most hospitals in Montana and Alberta were quite small and thus struggled with problems related to inadequate space issues and related bed shortages.

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[16] Alberta, Department of Public Health [hereafter DPH], *Annual Report 1914* (Edmonton: J.W. Jeffery, 1915), 223.
[17] Alberta, DPH, *Annual Report 1920* (Edmonton: J.W. Jeffery, 1921), 11.
[18] Rothman, *Living in the Shadow of Death*, 201-205.

A year following the sanatorium's opening, officials in Alberta conceded that although the plan had been only to admit incipient cases, "experience" had modified that attitude. The Chairman of the Department of Public Health observed that it had proven exceedingly difficult to "bar out" the moderately or far advanced cases, and many cases of a more advanced type had been admitted throughout the year.[20] Although not explicitly stated, it is apparent that dying tuberculosis patients were being cared for in the sanatorium, but it is not clear at whose insistence such care took place.

Tuberculosis remained a serious problem in Alberta during the interwar years. In 1925, there were 176 deaths from tuberculosis in the province, with 158 new cases reported.[21] In 1933, the Deputy Minister of Public Health claimed that lack of sanatorium accommodation was the most serious public health problem confronting Alberta.[22] In 1935, the fact that the tuberculosis death rate had been reduced by approximately one-third since 1926 was good news, but the urgent need for increased sanatorium accommodation meant that more needed to be done.[23] In 1936, Alberta became the second province in Canada to offer free tuberculosis treatment to residents. The *Tuberculosis Act* provided that any person who had resided in Alberta for one full year was eligible to receive free diagnostic services at provincial tuberculosis clinics, and if it was determined necessary, free institutional care at the Central Alberta Sanatorium. The Act stipulated that patients with pulmonary and other infectious forms of tuberculosis were to be given accommodation preference at the sanatorium, but the sanatorium officials continued to admit non-tubercular cases, including lung cancer patients, a practice they had engaged in since the institution had opened.[24]

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[19] Alberta, DPH, *Annual Report 1920*, p. 11.

[20] Alberta, DPH, *Annual Report 1921* (Edmonton: J.W. Jeffery, 1922), 14.

[21] These figures do not include tuberculosis deaths for Native Albertans. Alberta, DPH, *Annual Report 1925* (Edmonton: W.D. McLean, 1926), 8-9

[22] Alberta, DPH, *Annual Report 1933* (W.D. McLean, 1935), 11.

Although Montana did not welcome health seekers, the tuberculosis situation at the beginning of the twentieth century in Montana in some ways paralleled what was happening in Alberta. Health officials in Montana constantly faced rising rates of tuberculosis, especially in industrial mining centers such as Butte. The health hazards related to mining had become apparent to medical professionals by the turn of the twentieth century. The incidence of silicosis, an occupational disease that predisposed miners to pulmonary tuberculosis and pneumonia, rose substantially after 1880 with the introduction of power drills.[25] By the 1890s, Butte's health problems were "symbolic of industrial pollution."[26] Tuberculosis was clearly a man's disease in Butte. Between 1913 and 1914, only five of the 157 tuberculosis deaths were women; ten years later 137 men died compared to only eleven women and children.[27]

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[23] Alberta, DPH, *Annual Report 1935* (Edmonton: A. Shnitka, 1936, 1936), 13.
[24] McGinnis, "The White Plague in Calgary," 7.
[25] Alan Derickson, *Workers Health, Workers Democracy: The Western Miners' Struggle, 1891-1925* (Ithaca: Cornell University Press, 1988), 55.
[26] Duane A. Smith and Ronald C. Brown, *No One Ailing Except A Physician: Medicine in the Mining West, 1848-1919* (Boulder: University Press of Colorado, 2001), 107.

In 1915, an apparent lack of funding caused a health official to lament the inability of the department to carry on an effective crusade against tuberculosis, The official asked when the State of Montana would "wake up" and provide the Board of Health with as much money to protect the health of its population as it gave to the Live Stock Sanitary Board to "protect the health of the pigs."[28] Perhaps the state was more willing to expend funds on the health of pigs that were owned by solid citizens of the state—farmers—than on the health of miners, who were single transients. Still, the Montana state government likely felt that it had done its part for the health of Montanans by opening the Montana State Tuberculosis Sanitarium in 1913. During the sitting of the State legislature in 1911, public concerns about tuberculosis in Montana resulted in passage of a bill to establish a state sanitarium. State health officials were anxious to provide medical relief for tuberculosis sufferers as well as psychological relief for the public at large, whose fear and dread of the tubercular was paramount.[29] Rather than an influx of tubercular patients from outside of the state, the increasing numbers of the state's own mining population, especially those in Butte, proved the impetus for government action. A sanitarium, popularly known as "Galen," was established for the treatment of tuberculosis and for what was commonly known as "miner's consumption."[30] The institution was operated by the State of Montana, but not the State Board of Health.

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[27] Mary Murphy, *Mining Cultures: Men, Women, and Leisure in Butte, 1914-41* (Urbana: University of Illinois Press, 1997), 18-19.
[28] Montana, SBH, *Bulletin of the Department of Health* 9, no. 6 (1915), 2, available at the Montana Historical Society Research Center (hereafter MHSRC).
[29] Staudohar, " 'Food, Rest, and Happyness,' Part I," 52.

Although infected miners were expected to make up a large portion of the patient population, Galen was intended to serve all tuberculosis patients who could not afford treatment elsewhere. Patients with financial means, however, were expected to obtain their care privately.[31] From the time of its opening until at least the 1960s, patients were treated without charge, but a portion of the treatment cost, to a maximum of $1 per patient per day, was billed back to the patient's home county, city or town. Situated outside of and away from major Montana cities, Galen drew its patient population from all over the state. A physician who certified that the patient was suffering from tuberculosis or miner's consumption referred patients seeking admission. Patients were also required to supply a written request from their local authorities confirming that they were without financial means to pay for treatment. Indigent patients were given priority over private patients who had the ability to pay, and soldiers, sailors or marines were given priority over all admissions. As in Alberta, patients were required to have been a citizen of the state for at least one year before eligibility for treatment, except for females, who were required only to have been a resident of the state for the five months preceding the date of application for admission.[32] Although no apparent explanation for this interesting gender discrepancy exists, the policy may have reflected a desire by the state to maintain or increase the number of females in the state's population.

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[30] According to an information handbook published by the Montana Tuberculosis Association circa 1959, when a spur line to the sanitarium was constructed by the Northern Pacific railroad, the state engineer was asked to name the site. He chose to call it Galen, in honor of the State Attorney General, Albert J. Galen. *Montana State Tuberculosis Sanitarium* (Helena: Montana Tuberculosis Association, c. 1959) in Box T, Folder 38, Montana State Hospital Galen Campus Records, MHSRC (hereafter Galen Records).

[31] *Revised Codes of Montana 1921* (Helena: Bancroft-Whitney Company, 1921), "Chapter 115, Tuberculosis, Sanitarium," Section 1521, p. 682. The Code stated that "the preference in the selection of patients" should always be given to "the indigent."

Like sanatorium officials in Alberta, the officials at Galen worried about the disadvantages of housing both curable and incurable tuberculosis patients under one roof. In a Department of Public Health bulletin published by the Montana State Board of Health in November 1914, the sanitarium was praised for having done excellent work. The praise was especially deserved, suggested the writer, considering the patients who had been admitted to Galen, so many of whom had been "past all hope of cure." The writer went on to declare that although many patients who had been admitted in the incipient stage of the disease had improved or recovered, their cure had been "retarded by the depressing effects of having to associate with the incurables." The solution offered was to enlarge the institution so that the incurable tuberculosis patients could be "entirely separated" from the incipient cases.[33] It is not unusual that medical experts would recommend that the dying be kept separate from those who could be cured. In this instance, separate buildings would create an alternate space for the dying. From the medical profession's viewpoint, the "anywhere but here" philosophy prevailed. Even the average home was a better place for tuberculosis sufferers to die, although physicians were concerned that tuberculosis was contagious. Yet, the plight of those without a home would still be a problem.

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[32] *Revised Codes of Montana 1921*, p. 681.

[33] Montana, SBH, *Bulletin of the Department of Public Health* 8, no. 7 (1914), 2, MHSRC.

Worries about the mental states of curable patients were perhaps less pressing than the problems related to extreme bed shortages. Like the sanatorium in Alberta, the ongoing shortage of accommodations for tubercular patients persisted in Montana's state sanitarium from the time of its opening in 1913. Dr. Thomas Tuttle, the first superintendent of Galen (1913-1915), preferred to admit patients who were in the early stages of the disease, and he struggled with having to care for patients whom he believed had no chance of cure.[34] Although he requested that "only hopeful cases should be sent" and that they stay a maximum of one year, his earliest patients were very ill, far advanced cases.[35] The majority of patients admitted during Galen's first few decades of operation were diagnosed with "far advanced" pulmonary tuberculosis, while fewer were "minimally" or "moderately" advanced cases. Some patients were diagnosed with "terminal" tuberculosis or terminal silicosis upon admission. It is not entirely clear what the difference might have been between those diagnosed with far advanced tuberculosis, versus those who were deemed terminal, but evidence suggests that the word "terminal" was used primarily among medical professionals and hospital administrators, while the less ominous sounding term, "far advanced," was reserved for speaking with patients or families.[36] Two letters written by a later superintendent of Galen, Dr. Frank Terrill (1937-1957), to family members of Galen patients support this idea. In both letters, Dr. Terrill described the patient's condition as "very far advanced," although both patients' conditions upon admission were listed as terminal.[37] In one of the letters, the superintendent wrote that the patient's outcome for recovery was extremely bad, but he promised that he and his staff would do all they could "to make him comfortable."[38]

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[34] Connie Staudohar, " 'Food, Rest, and Happyness,' Limitations and Possibilities in the Early Treatment of Tuberculosis in Montana, Part II," *Montana* 48, no. 1 (1998): 46.

[35] "Report of the Executive Board," Governor's Papers, folder 7, Box 330, MHSRC. [hereafter Governor's Papers].

[36] Ruth Abrams et al., "Terminal Care in Cancer: A Study of Two Hundred Patients Attending Boston Clinics," *New England Journal of Medicine* 232, no. 25 (June 21, 1945), 119.

Despite the intention of Galen's officials to treat only hopeful cases, from the time of its opening in 1913, Galen was forced to serve as a last resort for dying patients who had nowhere else to go for care.[39] In 1913, 42 percent of the patients admitted died in Galen, the following year 48 percent died, and in 1915 the highest percentage of deaths per admission was recorded when 57 percent of the total patient admissions died.[40] In 1919, the number of deaths taking place in the institution that he had taken over frustrated Dr. Charles Vidal, who served as superintendent at Galen between 1919 and 1937.[41] In an address before the Montana Federation of Women's Clubs in 1919, Dr. Vidal contemplated the "disposal" of "the hopeless cases" at Galen. His recommendation was that they be cared for by their own county or city, "in buildings prepared and adapted to their care, and where their last hours could be soothed and cheered by the presence of their relatives and loved ones."[42] Concerns about contagion, at that point, seemed insignificant. The best place for a dying tuberculosis patient, in Dr. Vidal's opinion, was not necessarily in a person's home, but it was in a person's hometown, in buildings built specifically for the dying. Even outside of the sanitarium, it was important to separate those who could be cured from those who could not.

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[37] Patient files 5886 and 5901, Box 80, Galen Records.

[38] Patient file 5901, Box 80, Galen Records.

[39] Staudohar, " 'Food, Rest, and Happyness,' Part II," 46.

[40] "Medical Statistics," Box V, folders 17-18, Galen Records.

[41] Montana State Tuberculosis Sanitarium, *Fifty Years of Progress* (1963), Galen Records, Box T, folder 38.

[42] C.K. Vidal, "Some Needs of the State Tuberculosis Sanatorium," Read before the Montana Federation of Women's Clubs, Glendive, Montana, June 6-9th, 1991 and printed in *Bulletin of the Department of Public Health* 11, 8 (August, 1919), 19.

The problem of having to treat the terminally ill persisted. Frustrated, Dr. Vidal wrote to Montana's Governor Joseph M. Dixon in January 1921 and blamed the congestion in his institution on the "profession's persisting in sending us hopelessly advanced cases." As Dr. Vidal complained, "I cannot manufacture accommodations out of thin air." [43] Some of Dr. Vidal's recommendations may finally have materialized, since as early as the following year, Dr. Vidal's outlook appeared more optimistic. In an address to the Montana Tuberculosis Association, he claimed that Galen was finally being used for what it was intended and had become "a place for cure" rather than "a place for people to die."[44] His optimism was well founded. As the figures in Table 3 show, the percentage of admissions resulting in death did decrease with each passing decade, although it is difficult to determine exactly what led to the improvement in these death rates. The improved outcome was likely attributable to the increasing number of patients who sought treatment earlier in the course of their disease, which with better, more effective treatment, increased the odds that they would survive.

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[43] Letter from Dr. Vidal to Governor Joseph M. Dixon, 18 January 1921, Governor's Papers, folder 6, Box 34.

[44] Montana Tuberculosis Association Minutes, October 20, 1920, American Lung Association Files, American Lung Association, Helena, Montana.

Table 3
Admissions and Deaths, Galen Sanitarium 1915-1950

Year	Admissions	Male	Female	Deaths	Admissions Resulting in Death
1915	44	31	13	25	57 %
1920	128	110	18	43	34 %
1925	183	125	58	60	33 %
1930	137	78	59	37	27 %
1935	145	79	66	34	23 %
1940	251	140	111	58	23 %
1945	254	168	86	52	20 %
1950	223	146	77	42	19 %

Source: Galen Records, "Medical Statistics," Box V, folders 17-18.

Terminally ill tubercular patients continued to be referred to Galen. Between late June 1936 and early November 1940, forty-six patients who died at Galen were clearly diagnosed as suffering from "terminal" tuberculosis, accounting for approximately thirty percent of all deaths at Galen during that period. Evidence suggests that proximal time to death may also have had something to do with identifying a patient as terminal. From the sample of the forty-six patients admitted with terminal tuberculosis between 1936 and 1950, only eight lived longer than one month. Three died within one day, another seven in less than one week, and the remaining twenty-eight survived less than one month. The majority of patients, thirty-nine in all, were men, nearly half of them single or widowed;

only seven patients were women.[45] Obviously, despite the desires of administrators that Galen escape its reputation as being a place to die, the reality was that throughout its history prior to 1950, Galen was a place where many patients died. Although it was not their express purpose, it is apparent that Galen medical staff regularly and consistently provided care to dying patients who had few other options with respect to location of care.

The discovery of antimicrobial drugs, especially streptomycin in 1943, and para-amino salicylic acid in 1944, finally brought the cure for tuberculosis that medicine and society had sought for over a century. By 1950, improved tuberculosis treatment including the introduction of wonder drugs, had lowered the death rate and overall number of deaths from tuberculosis significantly in both Alberta and Montana (Table 4).

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[45] Author's calculations from Admission and Discharge Ledgers, Volumes 4 through 6, Box 2, and Volume 13, Box 3, Galen Records.

Table 4
Tuberculosis Death Rates
and
Number of Tuberculosis Deaths
Alberta and Montana
1930-1950

Year	Deaths From Tuberculosis Alberta	Death Rate Tuberculosis Per 100,000 Population in Alberta	Deaths From Tuberculosis Montana	Death Rate Tuberculosis Per 100,000 Population in Montana
1930	319	48	337	62
1935	329	34	257	46
1940	321	29	225	40
1945	263	Not available	166	33
1950	135	15	114	19

Source: Alberta, DPH, *Annual Reports* 1930-1950; Montana, SBH, *Biennial Reports*, 1929-1950.

Overall, public and professional concerns related to tuberculosis in Montana and Alberta from the late nineteenth century to the middle of the twentieth focused squarely on dealing with the public health implications of the disease. Some people who were not expected to recover died in tuberculosis institutions, not because doctors or patients believed it was an ideal place for care of the dying, but because it was a place to treat patients. Despite medical interest in separating the curable from the incurable, fears about spreading the disease to the population at large required confinement of curable and terminal patients together.

Cancer

As tuberculosis receded as a public health concern across North America, worries about cancer heightened. For a short time in the late 1920s, some Canadian medical specialists even contemplated the existence of a relationship between the "white plague" of tuberculosis and the "dread disease" of cancer.[46] Because cancer did not have the same public health implications as tuberculosis, however, it was not considered an urgent matter by the health officials in either Montana or Alberta for most of the first half of the twentieth century. Yet, beginning in the 1920s, national studies in both Canada and the United States recognized that cancer was taking an increasingly deadlier toll on the population. In 1931, the death rate for cancer in Canada was estimated to be 96 per 100,000 residents.[47] That figure was similar to the cancer death rate in the United States for 1930, nearly 100 per 100,000 people.[48] Given population differences, the absolute number of deaths in the United States was much higher than in Canada. During the 1930s it was estimated that between 120,000 and 160,000 cancer patients died in the United States each year, while the Canadian figures were between 10,000 and 12,000.[49]

In Montana, public health officials slowly responded to the ever-increasing rates of cancer incidence and death. In 1910 cancer was the eighth leading cause of death in

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[46] Katherine McCuaig, *The Weariness, The Fever, and the Fret: The Campaign Against Tuberculosis in Canada, 1900-1950* (Montreal & Kingston: McGill-Queen's University Press, 1999), 81.
[47] Alberta, DPH, *Annual Report 1931* (Edmonton: W.D. McLean, 1932), 12.
[48] Barbara Clow claims that the death rate from cancer in the United States between 1900 and 1930 rose from 64 to nearly 100 per 100,000 residents. Barbara Clow, *Negotiating Disease: Power and Cancer Care, 1900-1950* (Montreal and Kingston: McGill-Queen's University Press, 2001), 40.
[49] Clow, *Negotiating Disease*, 11.

Montana and by 1930 it had become the second, passing accidents which had previously held the number two spot.[50] In 1919, health officials were sufficiently concerned about the disease to print an article listing "Thirteen Points About Cancer" in an issue of the Board's *Bulletin of the Department of Health*. The article, provided by the precursor of the American Cancer Society, the American Society for the Control of Cancer, was even at this early date promulgating the gospel of early detection.[51] In addition to providing statistics, noting symptoms, and dispelling popular cancer myths, the article warned readers of the dangers of any cures offered by non-surgeons. While heralding the promise of radium as a treatment for some cancers, it warned that "no medicine will cure cancer," claiming that anybody who advertised "cures without the knife" was merely playing upon patient fears of operations. Patients were admonished to obtain "competent medical advice" at the first sign of danger. [52] Cancer patients did visit doctors, and most did go under the "knife," since surgery was the major treatment for malignant cancer. Radiation was also used to treat cancer starting in the first half of the twentieth century, although the expense of "radon" meant that not everybody had access to it, and chemotherapy treatments were not introduced as a means to fight cancer until after 1950.[53] Since medical advances related to cancer were all associated with hospitals, the number of cancer patients admitted for treatment rose dramatically as the twentieth century unfolded, increasing the likelihood some would die in hospital.

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[50] Montana, SBH, *Sixteenth Biennial Report 1931-1932* (Helena: Naegle Printing Co., 1932), 32.

[51] For more on the history of early detection, see Barron H. Lerner, *The Breast Cancer Wars: Fear, Hope, and the Pursuit of a Cure in Twentieth-Century America* (New York: Oxford University Press, 2001), 242-50, 300; Kirsten E. Gardner, "By Women, For Women, and with Women': A History of Female Cancer Awareness Efforts in the United States, 1913-1970s," (PhD Dissertation, University of Cincinnati, 1999).

[52] Montana, SBH, "Thirteen Points About Cancer," *Bulletin of the Department of Public Health* 11, no. 9-10 (1919), 29.

[53] On the history of radiation or chemotherapy relative to cancer treatment in North America, see Ruth Brecher and Edward Brecher, *The Rays: A History of Radiology in the United States and Canada* (Baltimore: Williams and Wilkins, 1960); John E. Aldrich and

Although there was every indication that cancer was on the rise as the decades unfolded, Montana did not develop any statewide, comprehensive cancer programs prior to the mid-1940s. As was the case elsewhere in North America, volunteer organizations were instrumental in the fight against cancer.[54] After the Montana branch of the American Cancer Society (ACS) was formed in 1936, ACS committees and members worked to educate Montanans about the dread disease at the same time that they offered practical support programs for cancer sufferers.[55] A state cancer registry was established in Montana in 1946 with funds allocated by the United States Public Health Service (PHS), showing once again that health initiatives in this Western state were often initiated or supported by the federal government. The PHS made its investment so that it could continue to learn more about the incidence and epidemiology of cancer throughout the United States.[56] The registry remained the principal cancer program in the state until 1950, when a state-funded educational program and chest x-ray survey were launched. [57]

Brian C. Lentle, eds., *A New Kind of Ray: The Radiological Sciences in Canada 1895-1995* (Vancouver: Canadian Association of Radiologists, 1995); Charles R.R. Hayter, "Seeds of Discord: The Politics of Radon Therapy in Canada in the 1930s," *Bulletin of the History of Medicine* 77, no. 1 (2003): 75-102.

[54] For more on the history of the American Cancer Society, see Lerner, *The Breast Cancer Wars*, and Gardener, "By Women, For Women."

[55] *Treasure State Cancer News* 18, no 9 (April 1959), MHCRC.

[56] Montana, SBH, *Twenty-Fourth Biennial Report 1947-1948* (Helena: Montana Record Publishing Co., 1948), 8.

[57] Montana, SBH, *Twenty-Sixth Biennial* Report *1950-1951* (Helena: McKee Printing, 1951), 70.

Hospitals in Montana regularly treated cancer patients, and although cancer patients were admitted to be treated or cured, a portion of cancer patients did end up dying in Montana hospitals. For example, 140 persons died from cancer in Butte, Montana between 1914 and 1917.[58] Of those, eighty-nine persons (sixty-four percent) died at home compared to fifty-one persons (thirty-six percent) whose death took place in Butte hospitals.[59] At least several of the cancer patients who died in Butte hospitals died as a result of surgical treatment. For example, Margaret Davis died of post-operative shock in St. James hospital in 1914, following a hysterectomy to remove a cancerous uterus.[60] In 1916, Park McLure died following an operation to remove a malignant kidney tumour.[61]

As the twentieth century unfolded, cancers of all types were on the increase in Montana, but it was the increasing incidence of lung cancer across Montana that had a significant impact on transforming the medical mandate of the Galen Tuberculosis Sanitarium.[62] When Galen opened in 1913, only patients diagnosed with tuberculosis or miner's consumption were eligible for admission. The *Tuberculosis Sanitarium Act*, revised in 1921, required that any patient who arrived at Galen and was found not to be suffering from tuberculosis or miner's consumption be promptly returned to his or her home county at the expense of that county.[63] Yet a close analysis of patient admission and discharge records from Galen shows that lung cancer patients were admitted at least as early as 1926. However, the official record suggests that Galen administrators were not very eager to advertise that fact, both prior to 1950 and beyond. In an information handbook published by the Montana Tuberculosis Association in the late 1950s, only services related to tuberculosis care were listed, and the entire publication expounded on the wonderful tuberculosis work of the institution.[64] Subsequently, in a commemorative brochure published in 1963, Galen officials noted that they were experiencing an increasing demand to treat "chronic chest diseases," including pulmonary emphysema, chronic bronchitis, and bronchogenic carcinoma, more commonly known as lung cancer. The writer went on to state that although they were then taking care of some chronic chest patients, they believed that in the future new legislation would be needed in order to expand services to meet the emerging needs.[65] Galen was just one of the institutions that provided cancer care in Montana during the first half of the twentieth century.[66]

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[58] There were a total of 4,759 deaths listed in the Butte Mortuary Register between 1914 and 1917, thus the cancer deaths accounted for nearly three percent of all deaths reported in Butte during this period. Butte Mortuary Register, Volume 6, 1914-1917, Butte-Silver Bow Public Archives, Butte, Montana [hereafter Butte Mortuary Register].

[59] In addition to the Butte Mortuary Register, I analyzed the admission and discharge registers from the Galen Tuberculosis Sanitarium in the Galen Records and a funeral home ledger that recorded a portion of the deaths that took place in the Red Deer, Alberta, district between 1918 and 1936 in the Orme Funeral Home Records, Red Deer and District Archives, Red Deer, Alberta [hereafter Orme Records].

[60] Butte Mortuary Register, entry 27 September 1914.

[61] Butte Mortuary Register, entry 16 January 1916.

[62] It is difficult to say whether the number of cancer diagnoses grew because of increased incidence, or better diagnosis.

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[63] *Revised Codes of Montana 1921*, 681.

[64] Montana Tuberculosis Association, *Information Handbook: Montana State Tuberculosis Sanitarium* (n. p., 1959), Galen Records.

[65] Montana State Tuberculosis Sanitarium, *Fifty Years of Progress*, Galen Records.

[66] James Clark Fifield, *American and Canadian Hospitals: A Reference Book of Historical, Statistical and Other Information on the Hospitals and Allied Institutions of the United States and Possessions and the Dominion of Canada* (Minneapolis: Midwest Publishing Co., 1933), 688-697.

Galen admission records from 1913 through 1950 show that treatment of non-tubercular patients was a regular practice, in spite of the legislation that set out its preclusion. Apparently, hospital administrators disagreed with state health officials when it came to deciding who should be admitted to hospitals, or patient demands meant that Galen administrators were forced to deviate from state policy. Although I do not know how the medical professionals who ran Galen felt about treating non-tubercular disease, including cancer, physicians from all points in Montana referred patients with cancer with the understanding that Galen would admit those patients. That Galen officials so obviously downplayed the fact that they treated cancer cases, even into the 1960s, is an intriguing piece of the history of cancer care. Furthermore, it speaks to the idea that institutions, at least in this part of the North American West, adapted their government funded medical mandates and resources to existing medical needs.

One of the first cancer patients listed in the Galen admission ledgers was a twenty-eight-year-old housewife from Glasgow, Montana, who was admitted in 1929. Hers was the only admission of carcinoma out of a total of 197 admissions that year.[67] Her diagnosis upon admission was listed merely as "cancerous." After a nineteen-day stay, the woman was discharged with her condition noted as "unimproved."[68] Her death took place one week following her discharge.[69] A total of seventeen patients diagnosed with cancer were admitted throughout the 1930s, most of them listed as suffering from "pulmonary carcinoma." The majority of the 101 cancer cases admitted during the 1940s and the additional twenty cases admitted during the single year of 1950 were diagnosed with "bronchogenic carcinoma," a term which apparently replaced the earlier term. Thus, between May 1929 and December 1950, it appears that at least 139 cancer patients were admitted to Galen, an institution founded to treat tuberculosis.[70] There may have been even more cancer cases admitted under different diagnoses to give at least the appearance of conforming to legislative criteria.

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[67] Admission Ledger for the year 1929, Galen Records.
[68] Patient file 2209, Box 31, Galen Records.
[69] Montana Death Index, MHSRC.

Although Galen had unofficially broadened its mandate to include cancer treatment, officials were usually careful to admit only lung-related cancer patients. According to the admission records, only four patients were admitted for non-lung cancers between 1929 and 1950. In 1944, a divorced male from Philipsburg, Montana, was admitted with kidney cancer; he died in Galen just over two months later.[71] That same month a thirty-eight-year-old woman from Great Falls was admitted with bowel cancer and died six days later.[72] A seventy-one-year-old widow from Lolo entered Galen in 1949 with cancer of the esophagus, and lived for three months before dying in the institution.[73] In 1950 a widow from Great Falls was admitted with breast cancer. She was discharged two weeks later and died at home less than a month after her discharge.[74] Regardless of whether they died in Galen or returned home to die, at least 119 of the 139 cancer patients admitted to Galen between 1920 and 1950 succumbed to their cancers, all within three years of their admission to Galen. These figures are in line with broader North American statistics related to cancer survival rates during the first half of the twentieth century.

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[70] This figure of 139 came from my close review of the admissions ledgers for Galen. It indicates that cancer admissions represented only three percent of the 4,580 admissions to Galen between 1929 and 1950, but almost 13 percent of the total deaths at Galen during the same time frame.

[71] Patient file 5249, Box 73, Galen Records.

[72] Patient file 5258, Box 73, Galen Records.

[73] Patient file 6361, Box 87, Galen Records.

[74] Patient file 6503, Box 89, Galen Records.

As was the case with tuberculosis, the majority of cancer patients admitted to Galen were men, most of them miners. Only seventeen of the 139 cancer patients admitted between May 1929 and December 1950 were female. There were more men in the general population, so the skewed ratio is not entirely unexpected, but since almost all of the patients admitted to Galen were admitted for lung cancer, mining provides the best explanation for the predominance of male sufferers. Of the 115 male cancer patients admitted to Galen, almost half were or had been employed in the mines. The occupations of forty-three males (thirty-six percent) were listed as miners and smeltermen, and another fourteen (twelve percent) were occupied as laborers, switchmen and pumpmen, many of them likely mining jobs. By 1948, officials at the Montana State Board of Health compiled information from the new state cancer registry and noted a greater incidence of respiratory cancer in males as compared to females, concluding that this may have been due to occupational causes. Miners, they concluded, might have contracted cancer from exposure to arsenic dust and fumes.[75] The occupations listed for the seventeen women provide no insights into the origin of their disease: one was a student, and the remaining sixteen were listed as housewives.

Smoking provides another, albeit weaker, explanation for the predominance of male lung cancer sufferers in Montana. James Patterson has shown that while 50 percent of American males smoked in the decades between 1920 and 1960, women did not take up smoking in great numbers until after the Second World War.[76] Therefore, it is logical that lung cancer would have occurred among men more often than women prior to 1950.

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[75] Montana, SBH, *Twenty-Fifth Biennial Report*, 1949-1950, 45.

During this period, curing was the measure of success in scientific medicine. Clearly, as an institution that wanted to be viewed as a place of cure, admitting cancer patients worked against Galen's interests. Yet, many of the lung cancer patients were diagnosed as terminal upon admission. For example, when a sixty-five-year-old miner from Butte arrived at Galen in 1945, his condition was noted as "practically terminal." He died less than one month later.[77] Of the 139 cancer patients admitted to Galen between 1929 and 1950, seventy-one patients died in Galen and sixty-eight were discharged to their family's care. The seventy-one deaths that took place in Galen all occurred within one year of admission, nineteen of them less than a month after admission, forty between one and six months in the institution, and twelve occurring after six months or more.

As with terminal tuberculosis patients, terminally ill cancer patients received surrogate care at Galen. Of the seventy-one cancer patients who died in Galen, sixty-two were men, and over half of those men were unmarried.[78] A significant proportion of the men who died in Galen likely did so because they had nowhere else to go and nobody else to care for them. Such was the case for a forty-nine-year-old, divorced smelterman from Anaconda admitted to Galen in 1950. Doctors soon determined that the cancerous lesion on the man's lung was inoperable, but he remained at Galen until he died four months later. In his patient file, a note listing only a male friend in Anaconda as next of kin suggests that he had few other caregiving options.[79]

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[76] Patterson, *The Dread Disease*, 202-203.
[77] Patient file 5410, Box 75, Galen Records.
[78] The marital status for fifty-six of the sixty-two men who died in Galen is provided in the admission ledgers. One man was separated, four were divorced, eight widowed, sixteen single, and twenty-seven married.

We cannot know for certain that the patients who were discharged died at home, but it is safe to assume that most would have returned to their family's care for some period following their discharge and many would have died at home. At least forty-eight of the sixty-eight cancer patients discharged from Galen succumbed to the disease within two years of their discharge.[80] Three of the forty-eight patients died within ten days of their discharge, twelve died within eight weeks, thirty-one died within eleven months, and the remaining two patients died within fifteen and seventeen months respectively. It is not surprising that so many of the discharged cancer patients died, since only five of the sixty-eight discharged patients left Galen with an optimistic prognosis. Three of these five patients, originally diagnosed with bronchogenic carcinoma, were discharged as "apparently cured" after stays at Galen of between one and three months. Since these patients did not show up in the Montana Death Index over the twenty-four month period following their discharge, perhaps their prognoses held up, or they may have left the state. Of the remaining two patients who were deemed "improved" at the time of discharge, one may have remained well, but the other person died five months later.[81]

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[79] Patient file 6618, Box 91, Galen Records.

[80] I consulted the Montana Death Index, checking for each of the sixty-eight names in the index for the two years following the date of each patient's discharge. This search yielded dates of death for forty-eight of the sixty-eight patients discharged.

[81] Author's calculations from Admission and Discharge Ledgers, Volumes 4 through 6, Box 2, and Volume 13, Box 3, Galen Records; Montana Death Index.

All indications are that Galen officials preferred to discharge dying cancer patients, as long as those patients had caregiving options outside of Galen. Since forty-nine of the sixty-three patients discharged with poor prognoses were married, the chances that they had access to caregivers at home were significantly higher than if they had been unmarried, as was the case for most of the patients discussed above who died in Galen. Although it is impossible to know how much information Galen doctors actually provided to the cancer patients who were discharged from Galen, the discharge ledger recorded very poor prognoses for all of them.[82]

The available evidence suggests that doctors at Galen were providing palliative care to terminal cancer patients, regardless of whether they called it that. As they did for terminal tuberculosis patients, the staff at Galen went to some lengths to make terminal cancer patients more comfortable, both physically and psychologically. The case of a sixty-year-old, single, railway worker from Kalispell, Montana, who was admitted to Galen in late January 1949, is an excellent example of how Galen doctors filled both palliative care and surrogate caregiving roles. Prior to the man's admittance, Dr. Terrill wrote to his doctor in Kalispell. In the letter, Dr. Terrill recommended that the patient come to Galen for a period of observation. Dr. Terrill would then determine whether the patient's condition justified carrying out a "palliative" pneumonectomy. As Dr. Terrill explained, "quite often these people are made to feel considerably better if the carcinomatous lung is removed, even though there is no chance of a cure." Dr. Terrill advised the Kalispell doctor that if the patient's condition were such that the operation would not be "feasible," the patient would have to return to Kalispell. In fact, the bronchoscopy performed on the patient on the day that he arrived at Galen showed that no further surgical procedure could be performed. However, the patient remained at Galen until he died three and one- half months later. Material in this patient's slim file reveals that he likely had no other options but to spend his dying days in Galen, given that only a male friend was named as next of kin.[83]

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[82] Notations in the discharge ledger described the conditions of these sixty-eight patients variously as "unimproved," "inoperable," or "no further treatment could be given."

The Alberta government spent more money and energy than Montana to develop and maintain cancer care programs. This was the case despite the fact that Alberta and Montana experienced similar cancer death rates during the first half of the twentieth century, especially in the period prior to 1935 (Table 5).

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[83] Patient file 6272, Box 85, Galen Records.

Table 5 Cancer Death Rates and Number of Cancer Deaths Montana and Alberta 1920-1950				
Year	**Deaths from Cancer in Montana**	**Death Rate Cancer Per 100,000 Population in Montana**	**Deaths from Cancer in Alberta**	**Death Rate Cancer Per 100,000 Population in Alberta**
1920	282	51	279	Not available
1925	379	69	340	57
1930	424	78	482	73
1935	528	96	622	79
1940	618	110	759	95
1945	640	128	830	100
1950	733	124	997	110

Source: Montana, SBH, *Biennial Reports*, 1923-1950; Alberta, DPH, *Annual Reports* 1920-1950.

Furthermore, in 1950 the death rate from cancer in Montana was 124 per 100,000 population, while the death rate in Alberta was 110. These rates suggest that the cancer problem was actually greater in Montana than Alberta by the middle of the twentieth century, perhaps because miners and smelter workers made up a larger percentage of the labour force.

In Alberta, the development of a centralized provincial health care system in the first few decades of the twentieth century helped create the foundation for future cancer management. As the 1920s came to a close, national efforts to identify and treat cancer translated into provincial efforts to do the same, and in 1931 the executive of the Alberta Medical Association appointed a committee to study the "cancer situation" in the province. The committee recommended that a cancer questionnaire be sent to all physicians in active practice to canvas them for information about their observation and treatment of cancer cases. From that effort they apparently learned a good deal about what patients and practitioners experienced with regard to cancer. Unfortunately, neither the questionnaires nor the survey's summary appear to have survived.[84] The committee also urged the Department of Health to make cancer a notifiable disease, which it did in 1932.

More extensive reporting practices by Alberta's Department of Public Health, especially in the area of hospital statistics, allows for a clearer picture of terminal cancer care in Alberta than is possible for Montana.[85] Hospital statistics may not tell us much about the personal experiences of terminal illness, but they can be extremely useful in revealing where terminally ill people died and who cared for them. As in Montana, most people who died from cancer in Alberta died at home, not in hospitals. Statistics from a variety of other sources show that in 1929, only twenty-four percent of the 450 people who died of cancer in Alberta died in hospitals.[86] Thus, more than three quarters of all persons who died from cancer in Alberta that year died at home. Over time, the percentage of cancer deaths that occurred in Alberta hospitals increased (Table 6).

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[84] The Department of Public Health co-operated with the Alberta Medical Association in connection with the survey, but no further mention of the survey or its findings was made in subsequent annual reports. The survey was stunningly successful, with 732 questionnaires returned to the committee. Alberta, DPH, *Annual Report*, 1931, p. 12.

[85] Beginning in the 1920s, provincial hospital inspectors began to include statistical admission and discharge summaries from the various municipal hospitals in the province in the annual report. By the end of that decade, statistical summaries from all approved hospitals in Alberta, and some private hospitals, were also included.

[86] The percentage of cancer deaths was calculated from various statistical reports published in the annual report. Alberta, DPH, *Annual Report 1929*. The total of 450 is

Table 6
Cancer in Alberta Hospitals (Excluding Private Hospitals)
1933-1938

Year	Cancer Cases Treated in Alberta Hospitals	Cancer Deaths Reported in Province of Alberta	Cancer Deaths Recorded in Alberta Hospitals	Percentage of Alberta's Cancer Deaths Taking Place in Hospitals
1933	661	590	216	37 %
1934	755	572	255	44 %
1935	1092	622	262	42 %
1936	1118	641	279	44 %
1937	884	598	273	46 %
1938	976	681	318	47 %

Source: Alberta, DPH, *Annual Reports*, 1933-1938.

Although the percentage of cancer deaths in hospitals increased as the years passed, many of the cancer deaths in hospitals were likely related to surgical treatment. Hospital inspection reports reveal that cancer operations were among the least successful. In 1927 there were over 20,000 operations performed in the province, with only sixty-five to treat cancer. Only fifteen of these sixty-five cancer patients left the hospital alive, or put another way, over seventy-five percent of the patients operated on for cancer in

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from Alberta, DPH, *What You Should Know About Cancer* (Edmonton: King's Printer, 1930), 3.

Alberta hospitals in 1927 died in hospital.[87] As Table 7 reveals, the number of surgery-related deaths that took place in Alberta hospitals fluctuated throughout the decade of the 1930s.

Table 7
Cancer Deaths Related to Surgery By Type of Hospital
Alberta
1930-1938

Year	Cancer Operations in Approved Hospitals[88]	Cancer Deaths in Approved Hospitals	Cancer Operations in Municipal Hospitals	Cancer Deaths in Municipal Hospitals	Cancer Operations in Private Hospitals	Cancer Deaths in Private Hospitals
1930	132	10	12	1	0	0
1931	142	30	20	10	1	0
1932	-	-	-	-	-	-
1933	111	37	15	7	3	2
1934	99	25	13	9	3	1
1935	131	57	20	6	1	0
1936	151	96	9	12	1	0
1937	129	88	9	8	0	0
1938	273	97	17	18	0	0

Source: Alberta, DPH, *Annual Reports*, 1930-1938.

That only a small percentage of people dying from cancer died in hospital is born out in another sample of seventy-five cancer deaths in and around Red Deer, Alberta, between 1918 and 1936. In this sample, only thirty-six percent of deaths took place in the Red Deer Memorial Hospital. The majority of deaths, fifty-six percent, took place at home.[89] The remaining eight percent of deaths took place outside of the Red Deer District, in Edmonton, Calgary, Winnipeg or Victoria, where the patients had traveled to receive medical treatment. This sample is useful in that it provides some insight into where people living in predominantly rural areas died of cancer, and it confirms the practice of the terminally ill who could afford to do so traveling away from home to seek treatment, a subject discussed in more detail in the next chapter.

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[87] Alberta, DPH, *Annual Report 1927-28* (Edmonton: W.D. McLean, 1929), 17-18

[88] Approved hospitals in Alberta were those that received the provincial per diem subsidy and generally included all hospitals except private hospitals.

Alberta's political commitment to the ideal of granting Albertans equal access to medical treatment was illustrated again in 1940 when the Social Credit government passed the *Cancer Treatment and Prevention Act* to provide free diagnostic and treatment services to all Albertans.[90] Based on the model of cancer clinics developed in France and replicated across North America, the Alberta program established two clinics, one in Calgary and one in Edmonton.[91] The clinics were set up in large urban hospitals but they drew people in from all over the province. In 1941, over 1100 people attended the free clinics, with half of them diagnosed with cancer. Nearly thirty percent of the patients diagnosed with cancer at the clinics in 1941 were considered "hopeless," having had the disease for a long time before attending the clinic. Of the 159 patients then deemed hopeless, 109 died before the year ended, showing that survival statistics in Alberta during this time period were fully in line with broader North American survival rates.

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[89] Orme Records, 1918-1936. One of the columns in this funeral home ledger states whether the patient died in a residence or in hospital.

[90] It is not clear if the act applied to Native Albertans, but it is unlikely given that the health of Native Albertans was a federal responsibility.

[91] Patrice Pinell, "Cancer Policy and the Health System in France: 'Big Medicine' Challenges the Conception and Organization of Medical Practice," *Social History of Medicine* 4, no. 1 (1991): 75-101.

As was the case in tuberculosis sanatoriums a decade or so earlier, the medical professionals who operated the cancer clinics also expressed the belief that the dying did not belong in treatment hospitals. In 1942, the director of cancer services for the province stated that the "advanced and hopeless cases" should be treated in the rural hospitals, which would accrue less expense to themselves or to the districts in which they resided.[92] The director's discussion of treatment is intriguing. It seems as though he intended hopeless cases to be treated in their hometown hospitals, but he does not elaborate on what treatment would consist of for such advanced cases. It is difficult to know if his advice to return advanced cases to their own districts was taken, but we do know that many of the cancer deaths that took place in Alberta did take place in rural districts. For example, in 1944, the majority of cancer deaths in the province, thirty-eight percent in fact, took place in "rural Alberta," a further twenty-eight percent took place in Edmonton, twenty-three percent in Calgary, and the remaining 10 percent in "small cities."[93] Unfortunately, it is unclear whether, for instance, the people who died in rural Alberta, died in rural hospitals or at home.

Not all of the cancer and tuberculosis sufferers who died in medical institutions lacked family members to provide care, but the majority of them probably did. The evidence suggests that the absence of family caregivers was likely the primary reason that some terminally ill cancer and tuberculosis patients died in medical institutions in Alberta and Montana during the late nineteenth century and throughout the first half of the twentieth century. Obituary evidence repeatedly supports this hypothesis. For example, the deaths of two men, one in Montana and the other in Alberta, reflect the situation that single men who were dying of cancer often faced. In May 1915, Ben Senior, a sixty-one-year-old, divorced miner passed away from brain cancer at St. James Hospital. His obituary noted that his death took place after a long illness. Although it is not clear how long the Sisters of Charity had provided care to him, it is almost certain that his death took place in hospital because he had few caregiving options. According to his obituary, Mr. Senior "left no relatives in this city."[94] Similar circumstances prevailed in the case of Charles Swan, who passed away in the Wetaskiwin hospital in March 1923. An American from New York, Mr. Swan had been homesteading in Alberta for several years when he was diagnosed with cancer. In January 1923 he was admitted to the hospital for treatment, where he spent the last two months of his life. According to his obituary, Mr. Swan had no relatives in Canada.[95]

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[92] Alberta, DPH, *Annual Report 1942* (Edmonton: A. Shnitka, 1944), 100.
[93] Alberta, DPH, *Annual Report 1944* (Edmonton: A. Shnitka, 1946), 107.

A man's transient status, as much as his marital status, could create the need for terminal care in hospital. For example, obituary evidence shows that men without spouses comprised the majority of male cancer patients who died in Butte hospitals between 1914 and 1917. Some men were unmarried, others were simply working in Montana and Alberta while their spouses and families lived elsewhere. Out of a total of thirty-two men who died from cancer in hospital in Butte during this four-year period, nineteen were single, widowed, or divorced. Out of the thirteen married men who died in hospital, at least five made their family home elsewhere but were employed in various capacities in Butte. For example, bladder cancer was the cause of death of John Landry, a carpenter of Canadian origin who died in St. James Hospital in August 1916. His funeral notice stated that Mr. Landry was a recent arrival from Tacoma, Washington, and that his remains were being shipped back to his wife and five children in Tacoma.[96] This suggests that Mr. Landry, who may have fallen gravely ill quite suddenly, had no other option but to be admitted to hospital for terminal care since the person who likely would have been his primary caregiver, his wife, was 600 miles away.

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[94] Butte Mortuary Register, entry 22 May 1915; Ben Senior Obituary, *Butte Miner*, 23 May 1915.

[95] Obituary Collection, File S, City of Wetaskiwin Archives, Wetaskiwin, Alberta.

Conclusion

In the end, in both Alberta and Montana, politicians and the population at large supported the building of sanatoria and hospitals where people suffering from tuberculosis and cancer could be treated and sometimes cured. These institutions had some impact on the care of cancer sufferers during the early terminal or treatment phase, but neither fundamentally transformed the place where late phase terminal care was delivered or by whom. When curative efforts failed, government officials and physicians had very clear attitudes about the inappropriateness of their institutions as sites for terminal care. Although the development of hospitals sometimes resulted in increased options for those who were without caregivers, as long as a dying person had a family nearby, they were expected to return home to be cared for by family members. Hospitals may not have wanted to care for the dying, but as the following chapter illustrates, families did.

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[96] Butte Mortuary Register, entry 9 August 1916; John Landry Obituary, *Butte Miner*, 10 August 1916.

CHAPTER FOUR

Family Resources and Terminal Cancer Care

Hospitals and other institutions provided end-of-life care to some but not most dying people. In cases of terminal cancer care, family members were the primary caregivers until at least 1950 and most of that care took place in the family home. For example, nearly two-thirds of the cancer deaths that took place in Butte, Montana, between 1914 and 1917 took place in family residences. In Alberta in 1929, more than three-quarters of cancer deaths took place at home. Yet, scholars frequently suggest that families became less willing or able to care for sick and dying relatives in the late nineteenth and early twentieth century.[1] They claim that North American families transferred their caregiving responsibilities for sick and dying family members to hospitals. Some of the assertions and assumptions made by historians of health care about the factors that led the sick or dying to leave the home and "choose" the hospital must be re-examined. For example, Charles Rosenberg claims that after 1880 American families began to depend upon strangers for care "at times of sickness and approaching death."[2]

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[1] See, for example, Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (Baltimore: Johns Hopkins University Press, 1987), 8; Wendy Mitchinson and Janice Dickin McGinnis, *Essays in the History of Canadian Medicine* (Toronto: McClelland and Stewart, 1988), 14; Joan E. Lynaugh, "Institutionalizing Women's Health Care in Nineteenth- and Twentieth-Century America," in Rima D. Apple, ed., *Women, Health, and Medicine in America: A Historical Handbook*, 2nd ed. (New Brunswick, N.J.: Rutgers University Press, 1992), 258.

[2] Charles Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (Baltimore: Johns Hopkins University Press, 1987), 8.

Although greater numbers of nurses and physicians entered the home to care for the ill and dying, they did not replace family care. Rosenberg's claim that by 1920 the urban hospital had "replaced the family as the site for treating serious illness and managing death" is not borne out by the history of terminal care in Alberta and Montana.

David Gagan also ventures beyond his evidence when he claims that after 1890 "the modern family became less willing and able to accept responsibility" for the sick, as families "soon proved less capable of caregiving than the new profession of nursing."[3] Gagan consults no sources that provide evidence of the willingness or capabilities of family caregivers, and pays only cursory attention to professional nursing records. Similarly, in his recent (and otherwise excellent) book on the history of public general hospitals in Canada, Gagan and co-author Rosemary Gagan describe the "wholesale transfer of the care and treatment of the sick from the home to the hospital, which took place between 1890 and 1920" as a major social development.[4]

Scholars of family caregiving, often called domestic care or informal care, have begun to challenge the assumptions that the development of hospitals and expansion of nursing and medical professions made family care obsolete. As Peregrine Horden claims, "self-help and domestic care constitute the great submerged ice sheets of the history of health."[5] Fortunately, work by historians such as Emily K. Abel has begun to melt those ice sheets, and the history of informal care is an exciting and emerging product of the thaw. In *Hearts of Wisdom: American Women Caring for Kin, 1850-1940,* Abel challenges the "persistent assumption that family members lost responsibility for health care after the late nineteenth century."[6] Abel focuses on the chronically ill, but care of the dying does form part of her analysis since during the time period she studies, "sickness was likely to lead to death."[7] Abel demonstrates that there is clearly a history of continuity of family care of the sick in the home, most of it provided by female family members.

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[3] David Gagan, *'A Necessity Among Us': The Owen Sound General and Marine Hospital 1891-1985* (Toronto: University of Toronto Press, 1990), 28.

[4] David Gagan and Rosemary Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1890-1950* (Montreal: McGill-Queen's University Press, 2002), 3.

[5] Peregrine Horden, "Household Care and Informal Networks: Comparisons and Continuities from Antiquity to the Present," in Peregine Horden Smith, eds., *The Locus of Care*, (London and New York: Routledge, 1998), 23.

Work by scholars who investigate the history of family care of other marginalized groups, such as the mentally ill, has also informed my thinking. Patricia Prestwich, David Wright and others demolish the assumption that families had eagerly abandoned mentally ill family members to asylums by the late nineteenth century, and stress the continuity of family care throughout the early decades of the twentieth century.[8] Prestwich found that families did not commit loved ones to asylums until a later phase, when the "situation had become desperate."[9] Similarly, admitting a terminally ill person to hospital may have been a final and desperate attempt by family members to save the life of the person who was dying, not an effort to shun the work of caregiving.

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[6] Emily K. Abel, *Hearts of Wisdom: American Women Caring for Kin, 1850-1940* (Cambridge and London: Harvard University Press, 2000), 7.

[7] Abel, *Hearts of Wisdom*, 52.

[8] Patricia E. Prestwich, "Family Strategies and Medical Power: 'Voluntary' Committal in a Parisian Asylum, 1876-1914," *Journal of Social History* 27, no. 4 (Summer 1994): 799-818; Charlotte MacKenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asyum, 1792-1917* (London and New York: Routledge, 1992); David Wright, "Getting out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century," *Social History of Medicine* 10, no. 1 (1997): 137-155.

[9] Prestwich, "Family Strategies and Medical Power," 804.

The history of care of the dying may also parallel some of what took place with respect to the medicalization and institutionalization of the elderly in North American society during the twentieth century. In her history of residential care for the aged in British Columbia, Megan J. Davies recognizes that the availability of family care, or the lack thereof, shaped the last decades of life. Family affection, especially on the part of daughters, was a constant theme in the care of the elderly. Furthermore, Davies recognizes that family and social strategies dealing with care of the aged differed depending on whether the elderly lived in a rural or urban setting.[10]

This chapter draws on obituaries as sources that help to uncover the frequently hidden work of family caregivers. Historians have often turned to obituaries in order to learn more about how their historical subjects lived, and the cause and date of their subject's death, but they have generally disregarded the usefulness of obituaries in providing details about how people died.[11] Because obituaries were sometimes written by or with the input of family members, they provide necessary factual information about how patients and families coped with terminal illness and eventual death.[12] But as Janice Hume cautions, obituaries do more than simply relay facts; they invoke an ideology to the reading audience.[13] As Hume argues, "obituaries are text, too, constructed fragments of history."[14] How then should one read obituaries that exalt the virtues of family caregivers, knowing that it is possible that the obituary was prepared, at least in part, by some of the caregivers whose praise is being sung?

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[10] Megan J. Davies, *Into the House of Old: A History of Residential Care in British Columbia* (Montreal: McGill-Queen's University Press, 2003), 35, 39-41.

[11] On the use of obituaries for studying North American culture in the past and present, see Fredric F. Endres, "Frontier Obituaries as Cultural Reflectors: Toward 'Operationalizing' Carey's Thesis," *Journalism History* 11 (Autumn/Winter 1984): 54-60; Gary L. Long, "Organizations and Identity: Obituaries 1856-1972," *Social Forces* 65 (June 1987): 964-1001.

[12] Hume claims that even though newspaper reporters and funeral directors began to exercise more influence over obituary writing after the turn of the twentieth century, relatives, friends, and associates of the deceased continued to have at least some input into obituary content. Janice Hume, *Obituaries in American Culture* (Jackson: University Press of Mississippi, 2000), 97.

Furthermore, historians should approach obituaries cautiously because they sometimes fail to distinguish between location of death and location of care during the dying process, with the potential to erase the important work of women's family care of the dying. Obituaries frequently state whether the deceased person passed away at a family residence or in a hospital. Yet, families in Montana and Alberta sometimes admitted loved ones to hospital just hours or days before death occurred. The trip to the hospital often followed weeks or months of care at home. In the case of hospital deaths, obituaries often provide information about the timing of a cancer patient's admission to hospital. Pairing information from obituaries with data from other sources, such as the Orme Funeral Home Register or the Butte Mortuary Register, confirms that the place where a patient died was often different from the place where she or he had been cared for in the period preceding death.[15]

There is disagreement among scholars about the usefulness of using obituaries in cases of cancer. For example, in Barbara Clow's study of cancer care in Ontario, she dismisses the use of obituaries in the study of cancer on the ground that cancer deaths were "seriously under-reported in obituaries" during the first half of the twentieth century. Clow does not share the views of other scholars regarding the reason for underreporting. She rejects suggestions made by James Patterson and Susan Sontag that the reticence to name cancer and other diseases in obituaries was part of a "conspiracy of silence" by the press around the topic of cancer. Rather, Clow proposes that the reticence to discuss cause of death in obituaries must be examined in the context of a North American culture that valued privacy in matters related to illness and dying. [16]

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[13] Hume, *Obituaries*, 22.

[14] Hume, *Obituaries*, 129.

[15] Ruth Abrams et al., "Terminal Care in Cancer: A Study of Two Hundred Patients Attending Boston Clinics," *New England Journal of Medicine* 232, no. 25 (1945): 721.

My research supports Clow's conclusion that there was no "conspiracy of silence" precluding the discussion of cancer in the North American press. Her view that issues of privacy influenced obituary writers is also persuasive. There were conventions in place that guided obituary writers to be sensitive about health issues when reporting deaths. For example, Janet Hume, author of *Obituaries in American Culture*, claims that in the early twentieth century, newspaper writers were taught that, "When death is due to a common disease, the cause is not ordinarily mentioned in consideration for the feelings of readers of the paper who may be suffering from the same disease."[17] However, many of the obituary writers in Montana and Alberta disregarded any proscriptions, cultural or professional, against reporting or discussing cancer deaths.

In contrast to Clow's findings that cancer deaths were only revealed in a "handful" of obituaries, I located numerous obituaries in Alberta and Montana that reported cancer deaths. [18] Some obituaries even went into great detail about the pain and suffering that cancer victims endured. The differences in Clow's findings may be due to distinctive newspaper cultures. Clow surveyed only one daily, urban newspaper, the *Toronto Mail and Empire*, in order to evaluate how cancer deaths were reported.[19] However, I surveyed a variety of newspapers published in Alberta and Montana, including urban dailies and especially weekly rural newspapers. Obituaries from weekly newspapers were far more likely to yield details about people who passed away from cancer and the family members who cared for them. Rural publications were more open to discussing deaths, including cancer deaths.

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[16] Clow, *Negotiating Disease*, 21-22.

[17] William S. Maulsby's *Getting the News* (New York: Harcourt, Brace, 1925) quoted in Hume, *Obituaries*, 96.

[18] Clow, *Negotiating Disease*, 22.

Paul Voisey's history of the High River *Times* shows that the journalistic form of the small-town or rural weekly newspaper is different from the urban daily. For instance, the weekly "did not attempt to present news."[20] Rather, the rural press "satisfied psychological and social longings that other forms of media did not."[21] Thus, one can argue that the weekly did present news, but just a different type of news, one that was of direct interest to the community. John W. Bennett and Seena B. Kohl suggest that small town and rural newspapers regularly reported deaths and illness in the form of obituaries because illness and death in the community were seen as public events. Many readers might have heard about a person's death, and even the cause, before they read about it in their weekly newspaper, since even in the days before telephones, news traveled quickly.

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[19] Clow surveyed obituaries published in the *Toronto Mail and Empire* (which merged with *The Globe* and was renamed the *Toronto Globe and Mail* in 1936) for the months of January and August, at five-year intervals between 1900 and 1945. Clow, *Negotiating Disease*, 170 n. 117.

[20] Paul Voisey, *High River and the "Times": An Alberta Community and Its Weekly Newspaper, 1905-1966* (Edmonton: University of Alberta Press, 2004), xx.

[21] Voisey, *High River*, xxiv.

By the time people read the obituary they were often looking for more details about the death or for information about funeral arrangements.[22]

There was a clear distinction between the way that the *Butte Miner*, a daily publication in Montana's bustling urban center, and the *Red Deer Advocate*, a weekly paper serving a primarily rural population, wrote obituaries for cancer victims. The *Butte Miner* did not use the word "cancer" in any of the 125 obituaries located for persons who died from cancer between 1914 and 1917. That is in contrast to what took place in Red Deer's rural district. Between 1918 and 1936, obituaries in the Red Deer paper cited "cancer" as the explicit cause of death over fifteen percent of the time in obituaries related to the cancer deaths identified in the Orme register. This is substantially different from Clow's findings for her Toronto newspaper, where she found that overall the cause of death was cited only fifteen percent of the time, and cancer was mentioned specifically only a handful of times within that small percentage. [23]

In Alberta and Montana, even the obituaries that did not cite cancer as the explicit cause of death, often used language that other scholars describe as euphemisms for cancer. Barbara Clow criticizes essayist Susan Sontag and historian James Patterson because each one asserts that the term "lingering illness" was used in obituaries in the past as a euphemism for cancer.[24] Quite correctly, Clow claims that we cannot know which phrases served as euphemisms for cancer without "meticulous and exhaustive cross-referencing of death certificates with death notices."[25] It was exactly this type of meticulous and exhaustive cross-referencing that I conducted, although death registers were scrutinized, rather than death certificates.

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[22] Benett and Kohl, *Settling the Canadian-American West*, 173.
[23] Clow, *Negotiating Disease*, 22.
[24] Clow, *Negotiating Disease*, 21, 23. For the genesis of Clow's remarks, see Susan Sontag, *Illness as Metaphor and AIDS and Its Metaphors* (New York: Anchor Books Doubleday, 1990), 103; Patterson, *The Dread Disease*, 152.

Death registers provided information about the marital status of the people who died from cancer, but supplied no further details regarding the familial circumstances of the dead. In order to learn more about the circumstances surrounding the terminal care received by people with cancer, it was necessary to turn to more general archives. Specifically, obituaries or death notices were sought for the 140 cancer deaths in the Butte register, and the seventy-five cancer deaths in the Orme sample.[26] The success rate for finding obituaries was quite rewarding. Thanks to the existence of a large, alphabetically arranged and indexed obituary collection for the Red Deer District, obituaries were located for over seventy-five percent of the cancer deaths recorded by the Orme Funeral Home, and the *Butte Miner* yielded obituaries for ninety percent of the cancer deaths listed in the Butte Mortuary Register.

This innovative cross-referencing approach to an existing source—obituaries—allows one to more clearly identify cancer as the cause of death and thus to report that the term "lingering illness" did indeed serve in many instances as a euphemism for cancer. In fact, the link to cancer was further illustrated in several obituaries that described the decedent as having passed away from a "lingering illness" which was "from cancer" or "caused by cancer."[27] Aside from "lingering illness," other euphemisms for cancer that appeared again and again in the Red Deer obituaries were terms such as "long illness," and "painful illness." Overall, in the Red Deer obituaries, explicit references to cancer or the use of euphemisms for cancer were present in about 70 percent of the obituaries. In contrast, the *Butte Miner*, which never used the word cancer, only referred to death having taken place due to a lingering or long illness about 10 percent of the time, and writers never used the word "painful" in the obituaries for cancer deaths in this sample.[28] Whether clearly stated or euphemistically suggested, references to how long cancer patients lingered and suffered suggests that for some families, the dying trajectory took place over long periods of time. It is likely that the "burden of care" on family caregivers grew proportionate to the length of time that they were called upon to provide for a dying loved one.

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[25] Clow, *Negotiating Disease*, 21.

[26] For ease of reference, both obituaries and death notices or announcements are referred to hereafter as obituaries. In point of fact, obituaries are regularly longer and more commemorative of an individual's life than death notices or announcements, which usually chronicle only the death, funeral arrangements, and sometimes mention the names of the deceased's family. Janice Hume, *Obituaries in American Culture* (Jackson: University Press of Mississippi, 2000), 94.

Family Circumstances and Care of the Dying

The major prerequisite for adequate terminal care in the past, as in the present, has been the availability of one primary caregiver. Peregrine Horden claims that in the past, family or household size was not an accurate predictor of the "volume" of care available within that family and that the capacity for caring could not be assumed to increase proportionately with family or household size.[29] Yet, there appears to be at least some correlation between terminal care taking place in the home and the number of adults in the dying person's family. In particular, the chances that death would take place at home increased further if adult female family members lived close by, or were able to travel so that they could be with the dying person when death was approaching. As Peregrine Horden points out, it was often "near residence" rather than "coresidence" that determined who was able to perform as family caregiver.[30]

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[27] For example, Joseph Mitchell died at his sister's home in Red Deer after a lingering illness caused by cancer. Obituary, *Red Deer Advocate*, 15 July 1926.
[28] Nine out of 125 cancer deaths were reported as lingering illnesses, two from long illnesses, and one after a "siege" of illness.

The presence of several adult family members did not necessarily translate into more hands to directly tend the dying person, but it could mean that the primary caregiver had access to support in other areas, such as caring for young children, tending to farm or household chores, or providing financial support. In this study, many, but not all, cancer patients who received terminal care at home had more than one adult child or sibling. For example, when Christiana McDougall, an elderly widow suffering from liver cancer, died at her daughter's home in Penhold, Alberta, in February 1922, her adult children "were all present when the end came." No small feat for this family, given that Mrs. McDougall had eight children. Six of her eight children were sons, two of whom lived in the United States, two of whom lived elsewhere in Alberta, and two of whom lived in Penhold. One of her two daughters lived in Saskatoon and the other was Mrs. McDougall's primary caregiver.[31] Although the daughter with whom Mrs. McDougall lived likely provided the majority of care during her mother's illness, at least some of Mrs. McDougall's seven other children were sure to have provided a measure of support to both patient and caregiver as the end neared. Perhaps they provided respite care to the primary caregiver or caregivers, or at the very least were able to provide some level of emotional support to one another.

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[29] Peregrine Horden, "Household Care and Informal Networks: Comparisons and Continuities from Antiquity to the Present," in Peregine Horden Smith, eds., *The Locus of Care*, 31, 50.
[30] Horden, "Household Care and Informal Networks," 37.
[31] Christiana McDougall Obituary, *Red Deer Advocate*, 10 February 1922.

In families without grown children, even young children were sometimes forced to take on the role of caregiver. When her mother was diagnosed with terminal cancer in the early 1920s, twelve-year-old Rose Naglich of Bearcreek, Montana, assumed the role of primary caregiver. As Rose later recalled, her father, a Yugoslavian immigrant who delivered coal and firewood for a living, could not afford hospital care for her mother, nor could he afford to hire someone "to come in and help." Consequently, Rose missed a lot of school, since in addition to caring for her dying mother she was also responsible for tending to her three younger siblings. The toll on her education was severe, but it was minor compared to the emotional hell that this young girl went through knowing only that her mother "was going to die" and that "there was nothing I could do."[32] In fact, what Rose did in caring for both her mother and her siblings was considerably more than "nothing."

In most cases, the presence of young children in a home complicated or increased the terminal caregiving burden in a family, since family members had to tend to both the children and the dying person. This was the case regardless of whether the person was dying at home or in the hospital. If a relative could tend the youngest family members, a wife could be at her husband's side when his death took place in hospital. When Thomas Millar passed away from liver cancer after only a few days of care in the Red Deer Memorial Hospital in November 1921, Mrs. Millar was "enabled to be with her husband in his last days so far as possible" thanks to the assistance of a female relative who cared for the Millar's two young sons.[33]

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[32] Rose Naglich MacFarland, "Rose's Story," in Berma Saxton, ed. *Senior Reflections: Montana's Unclaimed Treasure* (Helena: MHA Ventures, 2002), 10-12.

Some family members recognized that the presence of children complicated the provision of terminal care in the home, but they pursued that option anyway. In one such instance, the adult daughter of a woman being treated at Galen for terminal lung cancer wrote to Galen administrators in August 1948 requesting that her mother be allowed to return to Bozeman so that she could provide her mother's care. The woman recognized what a challenge that would present:

> I realize she will be a care but though I have 3 small children and they are pretty noisey at times, if Mother will come home I shall certainly do everything in my power to make her happy and as comfortable as it is possible for her to be.

Despite this daughter's impassioned plea, her mother remained in Galen until she passed away in late September.[34] One can only speculate as to whether it was the doctors or the patient who decided that this woman would stay at Galen. If it was the mother's decision, she may have chosen to remain at Galen rather than be an added "burden" to her already busy daughter. Or, she might have felt that being cared for in her daughter's noisy household was not in her own best interests. Indeed, her doctors may have agreed with or influenced that thinking, and not only because of the effects that the children might have on the patient. By the end of the 1940s, psychologists increasingly worried that witnessing the death of a family member could have an "undesirable psychological effect" on the young.[35] In the end, although the explanations for why this particular woman stayed at Galen until she died remain speculative, her daughter's desire to act as her mother's caregiver appears resoundingly clear. Another explanation could exist altogether; perhaps the daughter was acting on her mother's request to get her out of Galen?

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[33] Thomas Millar Obituary, *Red Deer Advocate*, 25 November 1921.
[34] Patient file 6166, Box 84, Montana State Hospital Galen Campus Records, Montana Historical Society Research Center, Helena, Montana [hereafter Galen Records].

In addition to the influence of the age of caregivers and other family members on care of the dying, the age of patients also mattered. This is particularly true for cancer patients. Cancer was known even in the middle decades of the twentieth century as "an older person's ailment."[36] In Butte, people forty and over formed the largest cohort of those dying from cancer at home, eighty-six percent.[37] Similarly, data from the Orme Funeral Home register shows that ninety percent of the cancer victims were aged forty or more. Those who ranged in age from twenty-three to thirty-nine made up the other twelve percent, with the age for one of the dead unavailable.[38] Given that men and women who were just past or well past their child-bearing years were more likely than younger people to have adult children, they were also more likely to have access to caregivers who could provide terminal care in the home.

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[35] Abrams et al., "Terminal Care in Cancer," 722.

[36] James T. Patterson, *The Dread Disease: Cancer and Modern American Culture* (Cambridge: Harvard University Press, 1987), 33.

[37] Author's calculations, Butte Mortuary Register, Volume 6, 1914-1917, Butte-Silver Bow Public Archives, Butte, Montana [hereafter Butte Mortuary Register].

Gender and Family Caregiving

Over the past thirty years, many scholars and health policy analysts have identified the availability of a family caregiver as the primary factor in determining where terminally ill patients receive care. In the 1970s, Cartwright and others found that the major differences between those who died at home and those who died in hospital lay in the patient's household composition, specifically whether they had children, and even more particularly, daughters.[39] Writing in the early 1980s, nurse educator Harriet Copperman observed that the availability of a female spouse or other family caregiver was the crucial factor that would or would not enable the patient to die at home."[40]

An historical examination shows that the availability of a primary, usually female, caregiver was also significant in the care of the dying throughout the first half of the twentieth century, and was a key determining factor in where terminal care took place. Women have long been the primary caregivers of health care in the home. [41] Medical anthropologist Francie Saillant argues that constructs of gender are particularly important to the history of home care, given home care's "strong association with the social and cultural universe of women's work."[42] Gendered family expectations meant that the female members were the main providers of terminal care. As Pat Jalland points out, nursing duties at the deathbed were regarded as "women's work."[43] This gender ideology arose out of the mid-nineteenth-century "cult of domesticity" or "cult of true womanhood."[44]

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[38] Author's calculations, Orme Funeral Home Records, Red Deer and District Archives, Red Deer, Alberta [hereafter Orme Records].

[39] Ward, "Terminal Care in Malignant Disease," 419.

[40] Harriet Copperman, *Dying at Home* (Chichester, UK: John Wiley and Sons, 1983), 5.

[41] Nancy R. Hooyman and Judith Gonyea, *Feminist Perspectives on Family Care: Policies for Gender Justice* (Thousand Oaks, Calif.:Sage Publications Inc., 1995), 120. For useful introductions to the history of women and health care, see Judith Walzer Leavitt, *Women and Health in America: Historical Readings* (Madison: University of

In Montana and Alberta before 1950, few men took on the role of primary caregiver to a dying family member.[45] Yet families who lived in isolated and undeveloped areas of Montana and Alberta had to make do with whatever human resources they had available, which meant that male family members would have cared for a dying family member in some instances. This was certainly the case in childbirth, in which some men aided their birthing wives. In a Children's Bureau report on maternity care in a Montana homesteading community, published in 1919, an investigator for the U.S. Children's Bureau found that out of 359 women who had babies at home, forty-six

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Wisconsin Press, 1984; revised second edition 1999); Rima D. Apple, ed., *Women, Health and Medicine in America* (New Brunswick, New Jersey: Rutgers University Press, 1992).

[42] Francine Saillant, "Home Care and Prevention," *Medical Anthropology Quarterly* 12, no. 2 (1998), 190.

[43] Pat Jalland, *Death in the Victorian Family* (Oxford, N.Y.: Oxford University Press, 1996), 98.

[44] Barbara Welter, *The Women Question in American History* (Hinsdale, IL: Dryden Press, 1973); and Gerda Lerner, *The Majority Finds Its Past: Placing Women in History* (New York: Oxford University Press, 1979).

[45] This is in line with John Mack Faragher's observations about gender roles in the American West. John Mack Faragher, *Women and Men on the Overland Trail* (New Haven: Yale University Press, 1979).

babies were delivered by the woman's husband. A further 129 births were attended by a physician, relatives or neighbours assisted with delivery for 184 women, and three women delivered alone.[46] Lacking other caregiving alternatives, husbands and fathers would have been as likely to take on care of the dying.

Only two specific instances of male caregiving over a seventy-year period in Montana and Alberta were uncovered in the present study. Both took place in the 1920s, and both were men who provided care to their dying wives. Even in these cases, the obituary evidence is ambiguous. After a four-year illness, Mrs. Fred Krause passed away in Red Deer in December 1921, with "all of the family gathered around her." Mrs. Krause had been "at the point of death" on several occasions but had rallied, "the constant loving care of her husband being greatly helpful in prolonging her life."[47] That Mr. Krause loved his wife and cared for or about her might be taken at face value, but the fact that at her death all of the family were gathered around her might suggest that Mr. Krause was not required to provide care on his own. In November 1925 in Red Deer, Mrs. J. B. Durand, "a woman of fine character and good education, devoted to her community and religious duties," passed away. Her obituary noted that her husband, who had "waited on her so assiduously during her illness," would certainly "have great sympathy in her loss."[48] That Mr. Durand had "waited on" his wife suggests that he could have been the primary caregiver. There were surely more men who cared for dying family members in Alberta and Montana over the period of this study. It is not clear whether obituary writers might have been less likely to emphasize male caregiving efforts because they deviated from established gender norms, or whether the above noted obituaries stressed male caregiving precisely because they were so unusual.

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[46] Viola I. Paradise, "Maternity Care and the Welfare of Young Children in a Homesteading County in Montana,"Rural Child Welfare Series No. 3, Publication No. 34; U.S. Dept. of Labor, Children's Bureau, 1919, cited in John W. Bennett and Seena B. Kohl, *Settling the Canadian-American West, 1890-1915* (Lincoln: University of Nebraska Press, 1995), 129.
[47] Mrs. Fred Krause Obituary, Red Deer Obituary Collection, 251, Red Deer and District Archives, Red Deer, Alberta [hereafter Red Deer Obituary Collection].
[48] Mrs. J. B. Durand Obituary, Red Deer Obituary Collection, 114.

Although men rarely took on the role of primary caregiver, male family members could still be governed by gendered expectations when it came to family care of the dying. As part of their filial responsibilities, men were expected to pay for the cancer care of parents. As the medical and nursing professions gained in stature, men who had the resources to hire someone to care for a dying family member were expected to do so. Such was the case for Walter Browne, a successful newspaperman in Butte. When Walter's 49-year-old mother, Nina Derby, passed away in June 1914, following a three-month-long ordeal with uterine cancer, her obituary informed the reading public that he had successfully fulfilled his obligation to his dying mother. The mother's obituary stated that as he mourned, Mr. Browne should take consolation that "even among a people in which parental devotion is expected, he set an exceptional example." Mr. Browne's associates had nothing but sympathy and respect for him because he had "left nothing undone" in his efforts for his dying mother. He had taken her to Baltimore to undergo "the new radium treatment," and throughout her travails he had secured for her "the very best medical attention and skilled nursing obtainable."[49]

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[49] Nina Derby Obituary, *Butte Miner*, 15 June 1915.

Although Mr. Browne was not responsible for providing "hands on" caregiving to his dying mother, his story illustrates another type of caregiving support that family members could provide. As breadwinners and providers, male family members could fulfill gendered expectations by paying for physical caregiving services that they would not be expected to provide themselves. A son would be much less likely to provide physical care to his dying mother than even a husband might be expected to provide to his wife. It simply would not be socially appropriate or acceptable for a son to tend to his mother's bodily needs. Nor, in all likelihood, would it have been acceptable for a son to care for his dying father's physical needs.

Despite men's contributions to end-of-life needs, it was the daughters, and sometimes daughters-in-law, who played the most significant role in the care of the dying. Adult daughters dominated the terminal caregiving landscape in Alberta and Montana before 1950. Evidence from the Butte and Orme registers and supporting obituary material show that many married men were cared for by their wives, but daughters cared for many of their fathers, and for most married women dying at home. This is borne out by the experiences of the Fergus daughters in the study of their mother's death from breast cancer. Two of Pamelia's adult daughters cared for her when she lay dying, while Pamelia's husband James tended to ranching business. Daughters sometimes cared for their dying fathers, even when their mothers were still living. When Arthur Oldford, a sixty-two-year-old farmer in Penhold, Alberta, passed away at home from cancer in May 1933, his obituary noted that his surviving wife was "not in the best of health," Fortunately, the Oldfords had raised ten children: five grown sons lived in the district, and two of their five daughters lived at home; another daughter was married but also lived in Penhold.[50] The Oldford sons might have provided supportive care, but it is more likely that the Oldford daughters, or daughters-in-law, cared for Arthur Oldford during his final days.

Adult daughters also assumed the care for widowed mothers dying of cancer. For instance, data in the Orme sample reveals that nine of the seventy-five cancer deaths listed between 1918 and 1936 were of widows. Obituaries located for seven of the nine indicate that four, and possibly five lived with their daughters when they died, and two others lived in their own homes but had married daughters who lived nearby. As with the Alberta sample, daughters also appear to have provided a large portion of care to widows who died from cancer in Butte, Montana. Of the nineteen widows who died between 1914 and 1917, seven were clearly cared for by adult daughters, one by her sister, and one by her mother; five died at the "family residence." [51] It is highly likely that female family members provided care to these remaining widows.

Historians disagree over whether gender norms were more relaxed in newly settled "frontier" communities.[52] My research reveals that in Alberta and Montana, women were the primary caregivers of the dying. The idea that women provided most of the caregiving labour is not new, but the idea that men did almost none of it, even in the

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[50] Arthur Oldford Obituary, *Red Deer Advocate*, 24 May 1933.

[51] Author's calculations from Butte Mortuary Register entries and related obituaries from the *Butte Miner*.

[52] For more on women's history in the Canadian West, see Catherine Cavanaugh and Randi Warne, eds., *Standing on New Ground: Women in Alberta* (Edmonton: University of Alberta Press, 1993); *Telling Tales: Essays in Western Women's History* (Vancouver, UBC Press, 2000).

West where some historians imagine that gender roles were less restrictive, is new. Today, caregiving remains primarily a female responsibility. However, more men are assuming terminal caregiving roles.[53]

Female Knowledge and Care of the Dying

Like other home health care practices, caring for somebody who was dying required skill. At each death, and all the stages in between, women brought their acquired home health care skills to the bedside. Women learned how to care for the dying because they had to and dealing with death at home was as much a part of life as dealing with birth at home. Where did women learn how to care for the dying? Was the knowledge passed down from generation to generation or was information passed between cohorts of women? Did women learn as they went along, gathering information through experience?

We know very little about the history of female care of the dying because scholarship on the history of family care in the home is still in its infancy. As Saillant notes, the history of home care "has been presented in the shadow of the medical institution and its historiography."[54] When historians have paid attention to the history of domestic health care, they operate with a limited definition that focuses on the tradition of self-help or "do-it-yourself healing," more or less restricted to the analysis of folk or domestic medicine.[55] However, there is an important distinction between the two. Folk medicine consists of "the traditional use of homemade remedies," which generations of families passed on orally. These remedies are "distinct rather than derived from professional therapeutics." In contrast, domestic medicine is "drawn from professional practice and generally disseminated through published writings rather than oral transmission."[56] In tending to the dying, women were required to draw on their knowledge of both folk medicine and domestic medicine.

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[53] Hooyman and Gonyea, *Feminist Perspectives on Family* Care, 120.

[54] Saillant, "Home Care and Prevention," 188.

[55] Published in 1977, *Medicine Without Doctors: Home Health Care in American History* is a thin volume of edited articles that focus on Buchan's *Domestic Medicine* and on the literature of the "self-help tradition" also referred to as "do-it-yourself healing." Much of the analysis treats the history of domestic medical practice as somehow outside of the

Saillant's ideas about home care as a form of "female knowledge" are instructive. She argues that while women have played key roles in forming, applying, and transmitting home care knowledge and practice, home care is usually examined "merely as work" and is rarely considered as "knowledge that has been passed on and shared as part of a historical and cultural legacy."[57] It seems reasonable to conclude that, like general home care knowledge, the skills for caring for the dying were passed down through generations, as well as between or amongst members of the same generation. Norah L. Lewis examines letters written by prairie women to the women's pages of farm and ranch magazines and newspapers between 1900 and 1920 to learn about sharing

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ordinary, belonging to "irregular" modes of medical practice. Guenter B. Risse, Ronald L. Numbers and Judith Walzer Leavitt, *Medicine Without Doctors: Home Health Care in American History* (New York: Science History Publications, 1977).

[56] Elizabeth Barnaby Keeney, "Unless Powerful Sick: Domestic Medicine in the Old South," in *Science and Medicine in the Old South* ed. Ronald L. Numbers and Todd L. Savitt (Baton Rouge: Louisiana State University Press, 1989), 276. See also, David J. Hufford, "Contemporary Folk Medicine," in *Other Healers: Unorthodox Medicine in America*, ed. Norman Gevitz (Baltimore: Johns Hopkins University Press, 1988): 228-264. In Canada, the limited amount of historical work that focuses on home-care practice centers on the study of home remedies and is structured around region. For example, see Norah L. Lewis, "Goose Grease and Turpentine: Mother Treats the Family's Illnesses," *Prairie Forum* 15, no. 1 (1990): 67-84; John K. Crellin, *Home Medicine: The Newfoundland Experience* (Montreal: McGill-Queen's University Press, 1994).

[57] Saillant, " Home Care and Prevention," 191.

home care knowledge.[58] Like others who write about home care, Lewis concentrates on home remedies, a type of folk medicine.[59] She argues convincingly that prairie women who wrote to and read these pages trusted home care knowledge offered by strangers as easily as they may have trusted information passed down from their female elders. Not surprisingly, the topic of terminal illness did not appear on the prairie women's pages.[60] Perhaps women did not pose questions about care of the dying in writing because knowledge about care of the dying was passed down orally, or they turned to family members or neighbors. Letters to newspapers were probably not the proper forum to discuss something like death, which had so many personal and emotional connotations. Furthermore, before 1950, dying was not looked upon as a medical issue.

The silence on death and dying in domestic medicine manuals further supports the idea that families saw dying as a non-medical matter.[61] Although home medical guides provided no instruction on how to care for a person in the final hours or moments leading to death, by the 1940s some guides provided information on how to confirm that a person was actually dead. For example, one of the authors of *The Modern Home Physician*, published in 1946, provided a list of physiological signs that one could check to assure that death had taken place. The signs of death constituted a "subject of great importance," claimed the author, "especially from the medico-legal point of view." The domestic medicine manual was a staple item in many if not most homes in Alberta and Montana, and North America generally. Families, especially those who lived in isolated areas without regular access to newspapers or mail delivery, depended upon these large, heavy volumes as their primary source of medical advice. Recall that in Montana in 1887, James and Pamelia Fergus learned that Pamelia had breast cancer only after they consulted all of the medical books in the house.[62] In his study of the rural community of Vulcan, Alberta, historian Paul Voisey cited the words of Elizabeth Akitt, a woman whose family moved to the Vulcan area early in the twentieth century. The "first thing" that Mrs. Akitt claimed to have done when she moved to her family's new homestead was to pay $10.00 for a "doctor book."[63] Men as well as women consulted these home medical texts, although women almost always concocted "home remedies" and passed on the recipes.

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[58] Norah L. Lewis, "Goose Grease and Turpentine: Mother Treats the Family's Illnesses," *Prairie Forum* 15, no. 1 (1990): 67-84.
[59] Lewis, "Goose Grease and Turpentine," 67.
[60] I reviewed ten months worth of a weekly prairie publication, focusing specifically on the women's pages or sections. *Free Press Prairie Farmer* (Winnipeg), 1 April 1917 to 1 April 1918.
[61] Victor Robinson, ed. *The Modern Home Physician: A New Encyclopedia of Medical Knowledge* (Toronto: The Musson Book Company Ltd., 1946), 195.

The advice in household manuals, alas, was often little comfort to those far from medical care. For example, how useful was it to readers of *The Household Physician* to read that those who suspected they had a malignant growth should "go to a doctor" to get an early operation.[64] Not much had changed for rural readers fifty years later, when in a chapter devoted to cancer, the author of the 1944 edition of *Modern Medical Counselor* advised readers to "see the best doctor you can find as soon as you see or feel any signs leading you to suspect cancer." He further advised, that no home treatment for cancer was of any use and "delay may be fatal."[65] This author provided not a single suggestion for what to do to ease pain or provide comfort when cancer entered the terminal phase.

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[62] Letter from James Fergus to Mrs. D.P. Shafer, n.d. 1887, box 14, James Fergus Papers, K. Ross Toole Archives, University of Montana, Missoula, Montana.

[63] Paul Voisey, *Vulcan: The Making of a Prairie Community* (Toronto: University of Toronto Press, 1988), 172.

[64] J. M'Gregor-Robertson, *The Household Physician: A Family Guide to the Preservation of Health and to the Domestic Treatment of Ailments and Disease* (Toronto: J.E. Bryant Co., 1890), 262.

Although readers found no specific information on how to care for somebody who was dying from cancer or any other disease, manuals such as the *The Household Physician* of 1890 sometimes introduced and explained the concept of palliative care:

> Palliative treatment is employed to lessen the pain, discomforts, or severity of a disease that cannot be cured, or that must be allowed to run its course. This treatment in a case of very painful cancer would consist in giving opium or morphia, or other drugs, to relieve the pain. . . . Palliative treatment means placing the system under the best conditions in the circumstances.[66]

Although more research needs to be undertaken to learn how women acquired terminal caregiving knowledge, it seems fair to say that knowledge was as likely to be acquired through generational transmission and experience, as through books. Even those without knowledge or experience would have been forced to adapt what caregiving skills they had to deal with a dying family member.

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[65] Hubert O. Swartout, *Modern Medical Counselor: A Practical Guide to Health* (Oshawa, ON: Signs of the Times Publishing Association, 1944), 822.
[66] M'Gregor-Robertson, *The Household Physician*, 14.

Diagnosis and Truth Telling

Even before 1950, when cancer concerns grew dramatically, a cancer diagnosis in any family was a devastating blow. Today, when faced with a cancer diagnosis, patients and family members usually adopt a hopeful and optimistic outlook as their primary weapon against forms of the deadly disease. It is difficult to know whether that was the case for patients and families in the past. Yet, they too struggled with the devastating emotional and psychological upset that accompanies a cancer diagnosis, sought out treatment, and hoped for the best.

Until 1950, and perhaps even later, physicians wrote of cancer with a sense of helplessness and despair, at least amongst themselves. A word that appeared frequently in relation to persons diagnosed with very advanced cancer was "hopeless." For example, in 1941, the father of a Galen lung cancer patient was advised that the outlook for his son's recovery was "practically hopeless."[67] In late fall 1947, a daughter learned that her mother had been diagnosed with cancer, and that doctors at Galen were very sorry but all that they could do for the patient was to "make her as comfortable as possible." Regarding the same patient, the dying woman's general practitioner was advised that, "of course, the outlook in this case is hopeless."[68]

Decisions about how and where a dying family member would be cared for and by whom were often influenced by the amount of information that the family received at the time of a cancer diagnosis. Knowing that death was imminent might have helped family members to plan for terminal care, but physicians could rarely predict when death would take place.

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[67] Patient file 4362, Box 61, Galen Records.
[68] Patient file 5875, Box 80, Galen Records.

Some families operated with full knowledge that death from the cancer was inevitable. In some cases, doctors openly communicated a terminal prognosis to family members, although family members sometimes chose not to tell the patient that he or she was going to die. Having to keep that truth from a loved one added stress for family caregivers. Sometimes, family members colluded with physicians to keep the truth from the patient. The family of a sixty-one-year-old railroad brakeman with inoperable lung cancer elected not to tell him that his days were numbered when he was released from Galen in 1948. Although the family was fully apprised of the situation, they elected to tell the man that everything that could be done medically had been done, and that nobody could be sure "of the results."[69] The man was returned to the care of his family and died at home seven weeks later. In 1949, a fifty-three-year-old housewife from Havre was discharged from Galen after doctors determined that a malignant tumour in her left lung could not be removed. The woman's relatives were advised of the inoperability but "requested that she be uninformed of the true nature of the disease." Apparently, the woman's physician obliged. Several months following her discharge, and just a few months before her death, the woman wrote to her doctor and complained that "this old arthritis is trying hard to get me down - but I can still fight back!"[70]

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[69] Letter from Dr. Terrill to patient's family doctor in Great Falls, Montana, 6 October 1948, Patient file 6204, Box 84, Galen Records.

[70] Letter from Patient to Dr. Terrill, n.d., Patient file 6282, Box 85, Galen Records..

Although physicians employed the term hopeless in communications with other physicians and with family members of the afflicted patient, it is less clear whether they used the term when speaking to their patients. Obituary evidence sometimes clarified who knew that they were dying, and who did not, but not always. For instance, when James Atkins passed away in Red Deer in November 1928, he "had known of later months that his call was coming."[71] When 33-year-old Mrs. Crosby of Eckville, Alberta, died in 1921, her obituary noted that she had "been threatened with a serious malady for some months." Consultations with medical experts in both Calgary and Edmonton two months prior to her death had "brought no hope of relief, her stay on earth being predicted almost to a day."[72] Obviously, somebody in her family knew that Mrs. Crosby was expected to die, but it is not clear whether Mrs. Crosby herself knew anything about how hopeless her situation was deemed or the dire prediction regarding the timing of her death. Similarly, according to his obituary, when Thomas Wells, of Red Deer, Alberta, was sent home from the Red Deer Hospital in January 1931, his cancer had reached "an incurable stage" and there was "no chance of recovery." It is not clear whether Mr. Wells knew that he was not going to recover, but his family must have. Mr. Wells died three weeks following his hospital discharge.[73]

Honest communications among physicians, caregivers, and a dying person would have facilitated decision making about some end-of-life issues, such as where care would take place, and who would provide it, but available sources do not provide much insight into whether honest communication was the norm. How and what a physician told a patient or family about a terminal condition was also influenced at least in part by Christian beliefs about the need for spiritual preparation at the end of life. Thus, in the nineteenth century physicians generally advocated telling patients that death was near so that the patient could prepare to meet his or her maker.[74] This philosophy persisted into the twentieth century, although suggestions as to the timing and manner of how patients should be told that they were dying varied. In a treatise published in 1902, a leading expert in medical ethics insisted that the family of the dying person ought to receive the bad news first, and that the patient should only be told the truth if he or she insisted.[75]

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[71] James Atkins Obituary, Red Deer Obituary Collection, 6.
[72] Mrs. Crosby Obituary, Obituary Collection, File C, City of Wetaskiwin Archives, Wetaskiwin, Alberta [hereafter Wetaskiwin Obituary Collection].
[73] Thomas Well Obituary, Red Deer Obituary Collection, 526.

Even patients and families who had treatment options and could afford it sometimes chose not to for personal or cultural reasons. In addition to a fear of hospitals, many people feared and distrusted cancer treatment, and often for good reason. Doctors lacked confidence in treating the disease, and the public picked up on their unease. People's uncertainty was enhanced by the fact that scientists and doctors could not come to agreement on either the causes of cancer or the appropriate treatments for the disease and families had little confidence in a medical system whose only clear message was early detection.[76] In this atmosphere, not seeking treatment for cancer may have been a practical option for a cancer patient and his or her family. As James S. Olson claims, during the first half of the twentieth century, some women preferred to die from breast cancer rather than submit to its surgical treatment.[77]

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[74] On the religious preparation for death, see Sheila M. Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (New York: Basic Books, 1994), 112, 114; Pat Jalland, *Death in the Victorian Family* (Oxford and New York: Oxford University Press, 1996), 17-58.

[75] Jalland, *Death in the Victorian Family*, 109-111.

[76] Barbara Clow, *Negotiating Disease: Power and Cancer Care, 1900-1950* (Montreal and Kingston: McGill-Queen's University Press, 2001), 56-57.

Family Care During Treatment

Most people diagnosed with cancer did seek out some form of medical treatment, at least initially. In most cases, treatment involved hospital care. Family members stayed close by throughout the treatment phase. Despite the medical uncertainties surrounding cancer, most families felt some obligation to seek whatever curative efforts were available at the time. Families turned to hospitals as sites to prolong life; they did not choose them as places where loved ones should die.

To date, few health care historians have investigated the important roles that family members played when people were admitted to hospitals. Emily K. Abel has questioned the familiar argument that family members were relieved of caregiving obligations when sick family members were admitted to hospital. Focusing on the 1910s, Abel suggests that hospitalization of a family member freed a family caregiver from some tasks at the same time that it created others. In her illustration of this point, Abel points to family members who found themselves having to monitor nurses.[78] Ultimately, even in hospitals, family caregivers retained responsibility for ensuring that a sick or dying loved one got the best care available, even if somebody else was delivering that care.

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[77] James Olson, *Bathsheba's Breast: Women, Cancer and History* (Baltimore: Johns Hopkins University Press, 2002), 45.
[78] Abel, *Hearts of Wisdom*, 108.

In Montana and Alberta, family members also remained involved and engaged with patients who were admitted to hospitals for cancer or terminal care. In most cases, family participation included assistance with patient care in hospital, and often extended to being physically present when death took place. However, even when family members could not be present, they were anxious to remain in communication with loved ones who were undergoing treatment away from home, and kept in communication with hospital professionals in order to track the progression or decline of the patient's condition. In 1950, the wife of a fifty-year-old lung cancer patient at Galen insisted on being kept informed of her husband's condition, and requested that in case of emergency she be notified by telegram as there was no telephone in her apartment in Billings and her landlady was "not responsible or dependable for delivery of messages."[79] Even great distances did little to dilute concern for a sick family member. In another Galen case, the director of patient services kept a running correspondence with the sisters of a fifty-two-year-old miner who spent seven months in Galen before dying there. When the man died, his sisters, both of whom lived in Scotland, were assured by the Galen official that their brother's death was "something of a release for him," since he had experienced "a good deal of pain."[80]

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[79] Patient file 6627, Box 91, Galen Records.
[80] Patient file 3067, Box 42, Galen Records.

Travel for Treatment and the Mayo Clinic

The extent of movement in and out of hospital, as well as the distances that some people traveled for cancer care, is astonishing. This notion of "travel for treatment" deserves more attention from historians of medicine, who are more likely to focus on what happened when the patient got to the hospital, than on the efforts or instances of the travel itself. Clearly, not everybody could exercise the option of traveling for treatment. Some people might have been too ill to travel, and for many others, the cost was simply prohibitive. In 1921, the train fare from country towns to Edmonton or Calgary was $5 per person. In addition, medical and hospital fees might have been anywhere from $25 for a consultation to $100 for an operation, as well as an average of $5 per day for hospital stays.[81]

Just as newspapers contain obituaries that provide insights into how and where people died, newspapers also provide evidence about the incidence of patient and family travel related to cancer treatment. Most of the newspapers reviewed in the current study had at least one column dedicated to reporting the comings and goings of the community's citizens, including the sick. For example, the *Livingston Enterprise* ran a column that was entitled "Reports from the Hospitals," which listed the patients in hospital and the nature of their ailment. Voisey refers to a similar column in the High River, Alberta, newspaper. The name of the column in that paper was "Town Topics Tersely Told."[82]

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[81] Barbara E. Kelcey and Angela E. Davis, *A Great Movement Underway: Women and the Grain Growers Guide, 1908-1928* (Winnipeg: Manitoba Record Society, 1997), 205.
[82] Voisey, *Vulcan*, 32.

In Alberta, obituaries often mentioned that residents of small communities went to larger communities for hospital treatment. Some people sought medical care in Edmonton or Calgary, others consulted "the best doctors in the province." In 1918, the obituary of eighteen-year-old Gladys Matatall of Wetaskiwin indicated that she had "been a patient sufferer for over two years from a declining illness which could not be checked although the best of medical aid had been summoned in Canada and the United States." [83] Clearly, Gladys had traveled for medical assistance.

Furthermore, between 1910 and 1940, at least a handful of terminally ill cancer patients from Montana and Alberta traveled to the Mayo Clinic in Rochester, Minnesota, to consult cancer specialists. Obituaries and newspaper columns make frequent references to Albertans and Montanans making the trip to the Mayo clinic, where the result of the trip was very often a confirmation of the patient's terminal status. References to Albertans traveling to the Mayo Clinic are more frequent in obituaries than references to Albertans seeking cancer care in other provinces of Canada. This Alberta-Mayo Clinic connection was forged by the transportation system, by the American settlement of Alberta, as well as by the Mayo Clinic's reputation as a leading diagnostic center in North America. As the early decades of the twentieth century unfolded, general practitioners across North America increasingly referred patients to the Mayo Clinic, or to other large, renowned medical centers, to confirm a cancer diagnosis. [84] As long as they could finance the pilgrimage, getting to Rochester was not a problem for Montanans and Albertans since rail service was quite convenient from either place.

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[83] Gladys Matatall Obituary, Wetaskiwin Obituary Collection, File M.
[84] Helen Clapesattle, *The Doctors Mayo* (Minneapolis: University of Minnesota Press, 1941), 354.

Cancer sufferers who traveled to Rochester were usually accompanied by at least one family member. In 1927, Jacob Valli of Red Deer visited the Mayo Clinic, accompanied by his son. Mr. Valli had been diagnosed with stomach cancer six months earlier, and his trip to the Mayo Clinic was a last-ditch-effort to save his life. Unfortunately, the trip was "without beneficial results," and Mr. Valli passed away at home in Red Deer a month following his return from Rochester.[85] When John Thompson, of Lloyd, Montana, went to the Mayo Clinic in December 1939, his wife Clara and grown son Ralph made the trip with him. Mr. Thompson made several more trips to the clinic over the next year or so, and his wife accompanied him at least one other time. Presumably, since he made more than one trip, the purpose of his last few trips was treatment related, but treatment was ultimately unsuccessful, and he died at home in Lloyd in 1942, cared for by his wife and daughter. [86] Both of these men had more than just the trip to the Mayo Clinic in common; each was supported by family members who went the extra mile with them in order to see if their lives could be saved. None were.

The End of the Journey: Death at Home

For family caregivers, the absence of cure did not translate into failure to care. Eventually, most cancer patients exhausted curative and treatment options, and returned to home and family for end-of-life care. Today, when cancer patients are informed that there is nothing left to be done for them, they are often confronted with a choice of whether to die at home or in a hospital. In the early twentieth century, there were fewer options. Although the hospital was sometimes the option by default, home was definitely the expected location of care of the dying. In the home, family caregivers and other informal caregivers, frequently provided compassionate care to the dying. When professional medical care was provided, in home or hospital, it was as an adjunct to family care, not a replacement. Two obituaries illustrate this point. When Mrs. Staffek of Lavina, Montana, died at her daughter's home in July 1922, the occasion was not unexpected. Her obituary claimed that "tender care and medical skill were employed constantly for the ease and comfort of the patient sufferer, and the end was quiet and peaceful."[87] Similarly, James Cole passed away at the Wetaskiwin, Alberta, home of his daughter and son-in-law in March 1927, "despite the loving care of relatives along with the best of medical attendance."[88]

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[85] Jacob Valli Obituary, Red Deer Obituary Collection, 512.

[86] *The Chinook Opinion*, 7 December 1939, 18 January 1940, 4 July 1940, 5 March 1942.

Although tender and loving care by family members was incredibly important at the end of life, not all families were able to meet that standard. Some families got along better than others. As Emily Abel shows, caregiving "represented an extension of previously established patterns" in people's relationships, "not an abrupt change."[89] Family conflicts were probably more likely to intensify than to improve when critical health care situations, such as a dying family member, presented themselves. Although family circumstances and dynamics varied widely, even families that did not get along particularly well were governed by societal expectations that care of the terminally ill fell squarely within the purview of home and family.

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[87] Mrs. Staffek Obituary, *Lavina Independent*, 28 July 1922.
[88] James Cole Obituary, Wetaskiwin Obituary Collection, File C.
[89] Emily K. Abel, *Hearts of Wisdom: American Women Caring for Kin, 1850-1940* (Cambridge: Harvard University Press, 2000), 35.

Although questions about how family members made decisions about how best and where to care for the dying are deeply complex, most people — patients, physicians and family members alike—thought that the home was the appropriate place for terminally ill people to die, and the family the appropriate caregivers. For family members, wanting to provide that care was often about the needs of those family members to be near the dying loved one. The daughter from Bozeman, whose mother's plight was discussed earlier in this chapter, pleaded with her mother's lung cancer doctor at Galen:

> If there isn't anything to do for mother, when can we bring her home? I only have one mother and I certainly want what is best for her. I realize she probably receives more expert care at Galen, but unless she is still receiving treatment that can't be administered at home I'm sure she would much rather be where she can be with the family when she wishes.[90]

In fact, this lung cancer patient had not received any specific treatment beyond the biopsy that revealed her malignancy. Although this daughter thought that Galen could provide

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[90] Letter from patient's daughter to Dr. Terrill, 5 August 1948, Patient file 6166, Box 84, Galen Records.

"more expert" care for treatment, she believed that her mother needed loving care at the end of life. The physician response is unknown, but he may have agreed. In 1950 a 45-year-old male patient at Galen was diagnosed with inoperable lung cancer and requested that he be allowed to return home. His physician agreed, seeing "no reason why he should not enjoy his life as long as he is able at home."[91] For these individuals, the focus of an ebbing life was on living, on being with family, in surroundings familiar and comfortable.

Of course, although family members often expressed the desire to care for a dying loved one at home, they were usually uncertain about what was in store for them. In particular, there was never any way of knowing how long they would be required to provide care. For example, the families who cared for cancer patients at home often witnessed the ravages of the disease for protracted periods of time. As an illustration, the illness durations for sixty-two of the eighty-nine home deaths that took place in Butte are provided in the Butte Mortuary Register. The shortest trajectory was that of twenty-six-year-old Emily Johnson, who died of leukemia in 1914 after being sick for only ten days. Hers was the only dying trajectory of less than three months' duration.[92] Another twenty-four persons were sick for periods of between three and ten months, but the majority were ill for periods of one year or more. Twenty-five people were sick for one to four years, two people died after illnesses of five years, and one person suffered for six years and four months. Of the remaining ten persons for whom illness durations were provided, three were ill for "several" years, three were listed as sick for an "indefinite" duration, one was "unknown," and fifty-nine-year-old Lucy Peters was simply noted as having been afflicted with cancer of the liver for a "long time."[93] Long illness trajectories usually meant that intensive care was required from family members. When Frederick Hart died at home in Red Deer in 1932, he had been sick with cancer "for the past two years and more and had been almost eleven months in bed, gradually getting weaker."[94] The care that Mrs. Hart provided to her husband was of paramount importance, so much so that when she passed away two years later, her obituary emphasized the fact that she had some years earlier nursed her late husband through a lingering illness.[95]

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[91] Patient File 6622, Galen Records.

[92] Butte Mortuary Register, entry 3 January 1914.

Terminal illness can be hard to face for both patient and caregiver not only due to lengthy dying trajectories, but also because it often includes intolerable pain and suffering. Witnessing the agony of a loved one whose body is being consumed by cancer can be a profound and tragic experience for family members. Today's obituaries are usually devoid of any reference to a person's final moments, although they sometimes note that the deceased passed away "peacefully." In contrast, obituaries in the past were sometimes filled with the noises and images of terminal illness, and obituary writers often mentioned the pain that the deceased had endured, and sometimes went into quite a bit of detail about particularly difficult deaths. For example, in 1913 after an illness of several months' duration which she bore with "characteristic patience and heroism," Elizabeth Birkett of Bittern Lake, Alberta, "quit the scenes of earth, the long nights of pain and tears forever gone."[96] In August 1916, death "came as a relief to the sufferings" of a fifty-four-year-old Wetaskiwin woman who had been "afflicted with cancer" for eighteen months.[97] Some obituaries were even more explicit. When sixty-four-year-old James Atkins passed away in Red Deer from cancer, his obituary stated that he had been bed-ridden for months and "had wasted almost to a skeleton."[98] For family members, witnessing the painful demise of a family member suffering from terminal cancer must have been merely the last sorrow in a series of sorrowful moments linked together between diagnosis and death.

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[93] Butte Mortuary Register, entry 3 July 1914.
[94] Frederick Hart Obituary, Red Deer Obituary Collection, 197.
[95] Mrs. Frederick Hart Obituary, Red Deer Obituary Collection, 197.
[96] Elizabeth Birkett Obituary, Wetaskwin Obituary Collection, File B.

Conclusion

In *A Few Months to Live: Different Paths to Life's End*, the authors observe that today family care in the home remains a critical element in terminal illness, but physicians, nurses and health policy makers often overlook it.[99] With few exceptions, historians of health care have also failed to see its contributions. As this study shows, care of the dying by family members inside and outside of the home has been a critical piece of the history of health in North America.

When family care is explored in detail, the story that emerges is one of families continuing to care for the sick and dying at home well into the twentieth century. Prior to 1950, families participated in the dying process by managing the physical, emotional and spiritual aspects of terminal care, regardless of whether dying took place in a person's own home, in a hospital, or somewhere in between, such as in a relative's home. James

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[97] Maria Rostrom Obituary, Wetaskiwin Obituary Collection, File R.
[98] James Atkin Obituary, Red Deer Obituary Collection, 6.
[99] Jana Staton, Ira Byock and Roger Shuy, *A Few Months to Live: Different Paths to Life's End*, ix.

Patterson sums up the impact of the "deadly disease" on patients and families quite succinctly. Writing about cancer in the 1920s and 1930s, he reveals that the majority of cancer patients did not survive the disease, instead dying "sometimes slowly, miserably, and at enormous emotional and economic cost to their families."[100]

Obituaries in both Alberta and Montana pay frequent tribute to the caregiving efforts of family members, especially women. The burdens of caring for dying family members could be great, but women continued to care for dying loved ones because they believed it was loving, important work, work for which they had crafted a certain expertise. It was not a simple task by any means, and required not only knowledge and skill, but compassion and patience.

In the final analysis, caregiving knowledge and experience were often the greatest resources that families had to offer dying loved ones. In *How We Die: Reflections on Life's Final Chapter*, Sherwin B. Nuland declares that in the final analysis, "Death belongs to the dying and to those who love them."[101] The availability of a primary caregiver, in most cases a female member of the family, was the major ingredient needed to facilitate terminal care in the home. However, the burden of supporting a cancer patient through the stages of terminal cancer was often lessened by the participation of the patient in his or her own care, by other family members, and by persons from outside of the family and household. In the past, death not only belonged to the family, it belonged at home. The team of caregivers that worked together to facilitate dying at home is the focus of the next chapter.

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[100] James T. Patterson, *The Dread Disease: Cancer and Modern American Culture* (Cambridge: Harvard University Press, 1987), 113.

[101] Sherwin B. Nuland, *How We Die: Reflections on Life's Final Chapter* (New York: Vintage Books, 1995), 265.

CHAPTER FIVE

The Home as Hospice:
The Slayton Case Study

On 8 September 1927, Lizzie Slayton, a sixty-nine-year-old woman in Lavina, Montana, recorded the following entry in the diary of her husband Daniel Slayton:

> Pa passed away at 7:15 am. I was called by the nurse half hour before he passed away, suffering in great agony. I read the 103 Psalm and sung "Simply Trusting Every Day", and the nurse made a short prayer and we said the Lords Prayer. The children all here but Pearl and Ernest and Bert and Eunice. Reverend Alstad came over and read John 11 and made a prayer.[1]

Lizzie had taken over writing in Daniel's diary on August 20 when advanced bone cancer rendered him incapable of putting pen to paper. Although in the five months since his terminal cancer diagnosis he had participated fully in his own care, Daniel's rapidly deteriorating physical condition resulted at this time in the transition from "self-care" to being "cared for." Fortunately for Daniel and his family, a reliable team of lay and professional caregivers came into the home and accompanied the Slaytons through the final three weeks of Daniel's life. Daniel's diary chronicles his experiences as a terminally ill patient and reminds us that the patient is also an important member of the caregiving team. The diary, supplemented with other sources, provides a poignant picture of terminal illness, the gendered elements of caring for the dying in the home, and the strategies that families employed as they cared for their loved one in the weeks, days, and even hours leading up to death. The Slayton case study illustrates how informal and formal caregivers joined family members in assisting and accompanying the dying through the dying process.

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[1] Daniel Slayton diary, 8 September 1927, Daniel Webster Slayton and Lizzie Ellis Slayton Papers, Montana Historical Society Research Center, Helena, Montana. [hereafter Slayton diary]. Unless otherwise noted, all quotations in this chapter are taken from the Slayton diary.

Daniel's and Lizzie's entries in Daniel's diary are an excellent departure point for understanding the history of end-of-life care provided in the home. The entries themselves cannot be called introspective; they provide little insight into Daniel's or Lizzie's feelings and the emotional responses to terminal illness or care. Although the information contained in the daily chronicles is brief and to the point, it speaks volumes about the cadence and rhythms of rural life and death in small-town Montana. Despite Daniel's illness, life for the Slaytons was full of people and very busy. Lizzie's entries in particular contain a litany of references to a multitude of individuals, many of whom were family members, who passed through the doors of the Slayton home during Daniel's final weeks. By consulting additional sources, including a local weekly newspaper, a Lavina map, and several local history books, I was able to "flesh out" the identities of the people named in the diary and place them in the family drama unfolding in the Slayton household.[2]

As Emily Abel explains, "family caregiving is an intensely personal experience that can be fully understood only in the context of the relationships that nest it."[3] Family relationships were crucially important in Daniel's life and his death. Family members formed the nucleus of care in the home, but it was also the availability of both formal and informal caregivers from the community that allowed the Slayton home to function as a type of home hospice. Daniel's dying was a physical process that took place within a physical realm (his body), but it also played out within the contexts of a family, a household, and a community.

In a small, rural community such as Lavina, people were used to sharing and negotiating with one another to have their needs met. Neighbours were often called upon to help out in times of health crises, as well as with the birth of a baby. Similiarly, at the other end of life, Virginia H. Hine has noted that "deathbed nursing skills were once available through an extended kinship or a small-community network of personal ties."[4] One should not paint an idyllic portrait of small-town life in Montana or Alberta, since not all members of a community are valued equally by others. Still, it is reasonable to conclude that kin, friends and neighbors responded out of concern, and also from a sense of duty, obligation and hopes for reciprocity.[5] Like many families in the region, the Slaytons did not have a large number of extended relatives living nearby, but over the course of three decades they had formed close, personal relationships with other Lavina families. These relationships would prove instrumental to the Slaytons during Daniel's dying days.

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[2] Some personalities defied my research tactics, which forced me to write to the Musselshell Valley Historical Museum in Roundup, Montana, to ask if they could identify individuals. They were able to tell me that Eunice Randall was the local midwife, but have not answered my queries about Dr. Firey. Letter from Shirley Parrott to author, 7 December 2002.

[3] Emily K. Abel, *Hearts of Wisdom: American Women Caring for Kin, 1850-1940* (Cambridge and London: Harvard University Press, 2000), 36.

[4] Virginia H. Hine, "Dying at Home: Can Families Cope?" *Omega*, 10, no. 2 (1979): 180.

Background: Before Terminal Illness

The Slayton family's sorrowful journey began on 11 April 1927 when Daniel wrote in his diary: "Snowing quite lively and more on the ground than any time before. The Drs. finally told me I had bone cancer and they could do nothing for me."[6] In Lavina, where the Slaytons had lived since before the turn of the century, Daniel's diagnosis, illness, and eventual death was devastating to both his family and the community as a whole.

To more fully understand how a person died, one must first learn how he or she lived. How Daniel dealt with health matters in general influenced both his response to a diagnosis of terminal cancer, as well as the nature of his end-of-life care. It is necessary to examine that part of his life which preceded his cancer diagnosis to see what can be learned about Daniel's usual approach to health, illness, and professional medicine, as well as his financial, geographical, and practical access to medical and caregiving resources. All of these factors were key variables in his subsequent experience of terminal illness and terminal care in the home.

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[5] Abel reveals that obligations of "neighborliness" and health care reciprocity were most evident during times of childbirth and epidemics. Abel, *Hearts of Wisdom*, 38-39.
[6] Slayton diary, 11 April 1927.

Daniel had come to Montana in 1884 from Virginia and within a year was operating a successful sheep ranching venture. As a sheep and cattle producer he amassed some fortune and a great deal of property over the following two decades. He also owned the Slayton Mercantile Company and held a controlling interest in banks in both Lavina and nearby Roundup. A staunch Republican, Daniel had been a county commissioner, served in the Montana House of Representatives in 1911, represented Musselshell County in the State Senate between 1917 and 1919, and in 1920 was an unsuccessful candidate for the Republican nomination for governor. His volunteer and philanthropic efforts in the community were many. He was a founding and active member of the Methodist Episcopal Church, a supporter of prohibition and the Anti-Saloon league, and the major organizer of the local cemetery. In 1887 Lizzie Eldora Ellis had journeyed West from Virginia to marry Daniel, her longtime love. Over a period of ten years they had five children, two girls and three boys.[7] The children enjoyed a privileged childhood and youth, but the family's fortune began to evaporate in the mid-1910s, and drought, grasshoppers, hail, low commodity prices and bank closures during the 1920s pressed Daniel into personal bankruptcy sometime between 1924 and 1926.[8]

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[7] At the time of Daniel's illness Daniel's and Lizzie's children ranged in age from approximately twenty-nine to thirty-nine. Leland P. Cade, *Golden Valley County, Montana: Selected History* (Billings, 2001), 138.

[8] Biographical information for the Slayton family is provided in Gordon Albie, Margaret Lehfeldt, and Mary Morsanny, *Dawn in Golden Valley: A County in Montana.* (n.p. 1971), 142-145; Cade, *Golden Valley County*, 138-233.

Daniel, his family, and his friends all believed that an injury he sustained to his leg when he was "caught between two horses" during the first week of March 1926 was the underlying cause of his cancer. The "tissue trauma theory" of cancer was a popular belief at the time.[9] Daniel wrote in his diary that he had gotten a "bad jam" when a horse turned around and thrust him up against a stall gate. He was hurt so badly that he went straight to bed and his entries over the following days refer to his leg being "very lame" and to his being in "misery."[10] By mid-April he noted that he had "suffered all day from my hip joint to my neck" and that he could not be comfortable "in any position."[11] As the weeks passed he kept busy planting gardens and birthing lambs, but the amount of discomfort he experienced with his leg increased and his sleep patterns were upset so that some nights he was "not able to sleep scarcely any."[12]

Despite his increasing discomfort, Daniel was reticent to seek a physician's advice. His hesitation could have had a financial basis, or Daniel might simply have been a man who did not care to visit doctors. It could also have been a matter of inconvenience, as calling upon a doctor meant traveling at least a short distance since

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[9] The article announcing his death stated: "About a year ago one of his legs was badly crushed when he was caught between two horses, and it was from this injury that a cancer developed that finally caused his death." "Death Claims Dan Slayton, Mont. Pioneer," *Roundup Record*, 9 September 1927. Barbara Clow claims that in the early twentieth century, contagion, heredity, and chronic or acute tissue trauma were the various theories that patients, the public and the medical profession subscribed to "in the absence of a satisfactory explanation for neoplastic diseases." Barbara Clow, *Negotiating Disease: Power and Cancer Care, 1900-1950* (Montreal: McGill-Queen's University Press, 2001), 11.

[10] Slayton diary, 6-9 March, 1927.

[11] Slayton diary, 17 April 1926.

[12] Slayton diary, 18 April 1926.

Lavina had been without a resident physician since 1924.[13] Whatever the reason, Daniel did not seek medical treatment until April 28, a full seven weeks following his injury. On that date, he traveled to Roundup, a larger town located nearly twenty-five miles away. There, a Dr. Firey gave him "a great working over," which included taking an x-ray and Daniel decided to "doctor with him for a while." He could have chosen differently. Dr. Firey was one of the nearest physicians, but not the only one in either Roundup or the county. Throughout 1926 and 1927 other family members traveled to Ryegate, seventeen miles west of Lavina, and consulted (variously) with a Dr. Gates and a Dr. Ross.[14] Despite his resolution to "doctor" with Dr. Firey for a spell, Daniel made only one trip back into Roundup on April 29 for another "treatment." There were no further visits either to or from Dr. Firey or any other physician for the remainder of 1926.

As spring turned to summer, in addition to experiencing many days of "lameness," Daniel became increasingly frustrated that he tired easily. Still, he continued to "chore around" and tend to the business of everyday ranch life dealing with irrigation concerns, sheep shearing, hauling hay, and shipping sheep throughout the summer.[15] Through the fall and into early winter, Daniel's impairment evolved into more acute suffering, which caused him to seek new pain solutions on his own and also accept the help of friends who offered treatment and care. Heat was his primary home remedy as he frequently took hot baths and began to apply "hot applications" to his painful hip.[16] The Christmas of 1926 was a particularly painful time.

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[13] A Dr. Appelman practiced for several years in Lavina, but left in 1922. "News of Lavina," *Roundup Tribune*, 11 January 1923.

[14] Slayton diary, 31 October 1926; 7 January 1927.

[15] Slayton diary, 8 March and 24 April, 1926.

At the beginning of the new year Daniel once again resolved that professional treatment was an attractive alternative to searing pain, and he was determined to travel even further to get it. On January 7 he boarded a train to Harlowtown, nearly 50 miles away from his home:

> Brisk northwest wind all day…went to Harlowtown on 15 and back on 16. Had a work out with the osteopath and also got some medicine from Dr. Ross. Expenses: fares $3.28, Ross $2.00, Gruell $2.50, Medicines $1.75.

Daniel was apparently open to combining both "regular" and "irregular" methods of medical treatment, although he would not have viewed them in those terms. There is no way of knowing whether Dr. Ross, a "regular" physician, or Dr. Gruell, an osteopath, would have supported each other's treatment methods. Osteopaths advocated treating bodily ailments though manipulation, a system designed to improve circulation and other natural functions. To Daniel, osteopathic treatment would have seemed a commonsense solution for a leg injury.[17] The day after his trip, Daniel re-injured his leg when he slipped on the ice, prompting a return to Harlowtown where he "had another work over," although he noted "it don't seem to have done much good."[18]

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[16] Slayton diary, 21 November 1926.

[17] In the 1920s, osteopaths still disagreed amongst themselves about whether or not drugs should be given as part of osteopathic treatment. For more on the history of osteopathy in the United States, see Norman Gevitz, *The D.O.'s: Osteopathic Medicine in America* (Baltimore: Johns Hopkins University Press, 1982).

Daniel continued to seek various treatment methods to deal with his increasingly bothersome condition. By the end of January he was clearly becoming agitated and worn out as he wrote: "my knee very bad and wearing on my nerves." He gleaned some relief from keeping his knee in a "sweat blanket" and then on January 27 he wrote that his neighbors, the Tueneares, were over in the evening with an "electric machine" which "did not have much effect on me." The following day Enoch Bilden, a long-time friend and business associate gave him "a lot of rubbing and electric treatment, getting the battery to work pretty sharp." Physicians disagreed about the therapeutic benefits of electricity. The use of electricity by professionals and others began in the nineteenth century and came to an end by the late 1920s.[19]

Alternative methods, on their own, did not provide the relief that Daniel needed, and his pain and discomfort intensified. On a "very fine day" in February, Daniel decided to "go to Billings with the Mrs." On the first morning of their stay, Daniel went to see Dr. Henry Armstrong, a Canadian-born physician and surgeon who had completed his medical training at Trinity College, Toronto, in 1894 and who had been practicing in Billings since 1898.[20] Daniel "waited some time" before he got in to see the doctor. The doctor looked him over, gave him some pills to take and sent him on his way. In the afternoon he visited the "Riegers," two osteopaths who practiced in the same building as Dr. Armstrong, one of them on the same floor.[21] It is not clear whether on this particular day Daniel visited the osteopath at Dr. Armstrong's suggestion The osteopath gave Daniel an electric treatment, which was "pleasant," and a "workover" on his leg that was "pretty tough."[22] The cost of that visit was $2.50, the same charge that he paid to the osteopath in Harlowtown. He returned for treatments each day for the following four days and on his last day in Billings he met once again with Dr. Armstrong who had him "strip" and told him he needed to have his teeth x-rayed. For the second time in months, Daniel had combined a trip to a regular physician with a trip to an osteopath. Perhaps Dr. Armstrong prescribed, or at least supported, the osteopathic treatments. The supposed rivalry between osteopaths and regular physicians documented by historians may have been less of an issue in the rural West, as least at this time.[23]

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[18] Slayton diary, 10 January 1927.

[19] James Harvey Young, "Device Quackery in America," *Bulletin of the History of Medicine*, 39, no. 2 (1965): 154-162; Carolyn Thomas delaPena, "Designing the Electric Body: Sexuality, Masculinity and the Electric Belt in America, 1880-1920," *Journal of Design History*, 14, no. 4 (2001): 275-289.

[20] Since they were both Montana old-timers it is entirely possible that Daniel and Dr. Armstrong knew each other personally.

At the beginning of March, Daniel returned to Dr. Armstrong's office in Billings where once again to his great annoyance he was kept waiting, this time for an hour. His agitation at having to wait for the doctor may well have been a factor in his previous reticence to visit a physician, yet he did not hold the wait or the fact that the appointment did not go well against Dr. Armstrong. Daniel lay on the examination table for an excruciating half an hour "and got pretty nervous" when they "failed to inject the serum" as they "could not get the needle between the bones."[24] This appointment was the last time that Daniel and Dr. Armstrong were in each other's company, but Daniel's respect for the physician became clear over the following six months as Daniel continued to seek Dr. Armstrong's guidance through letter-writing and telephone calls. Although they would not meet in person again, Daniel and Dr. Armstrong had developed a therapeutic relationship that would evolve primarily through the mail.

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[21] The Polk Directory for 1923 lists DD Rieger at 307 Stapleton Bldg, Jno Rieger at 227 Stapleton Bldg. Dr. Armstrong's offices were listed as 203-204 Stapleton Bldg.

[22] Slayton diary, 4 March 1927.

[23] Paul Starr claims that osteopaths and chiropractors faced "vehement medical opposition" up until at least the 1930s. Paul Starr, *The Social Transformation of Medicine* (New York: Basic Books, 1982), 127.

Aside from meeting face-to-face with the doctor, at this point there were not many aspects of Daniel's medical treatment that could not have been replicated at his home in Lavina. He continued to receive home electrical treatments with Enoch Bilden giving him "an awful jolt" on March 15. On March 17 he "got another batch of medicine from Armstrong" but noted the next day that he was "no better" from taking the pills. During the next week he experimented with the medication, finding that it did little to alleviate his pain but that he slept better when he doubled the dose. After speaking by phone with Dr. Armstrong on the 21st Daniel remarked in his diary that the physician "thinks I will come out OK but wants me to use crutches and drink more water." Within days, he went to work making himself a pair of crutches, a reminder that people living outside of an urban center had to resort to self-sufficient methods to meet their medical needs.[25]

Relief continued to elude Daniel, but not for want of his trying. By April 6, when crutches, water and Armstrong's medication had done nothing to alleviate his suffering, Daniel took the train to Great Falls and was admitted to the Deaconess Hospital. It is interesting that he would go as far as Great Falls given that Billings had a large and modern hospital, St. Vincent's Hospital, operated by the Sisters of Charity of Leavenworth, Kansas. St. Vincent's was substantially closer, about 45 miles away compared to the Great Falls Deaconess hospital, which was just over 170 miles from Lavina. Yet, the Deaconess was definitely the hospital of choice for the Slaytons. They were even supporters of the hospital. As early as 1914, Daniel's diary refers to donations of "spuds and honey" sent to the Great Falls hospital by train.[26] In December 1922 and again in December 1923, Daniel and Lizzie's oldest daughter, Lydia, had been a patient at the Deaconess, treated for some undisclosed illness.[27] As recently as April 1926, one of Lizzie and Daniel's grandchildren had been born in the Great Falls hospital.[28] It is probable that Daniel's religious affiliation had everything to do with his choice of hospital. As a very devoted Methodist, Daniel would not have been comfortable supporting a Catholic enterprise such as St. Vincent's, even if it was closer to home. This is similar to what transpired with regard to the Fergus family, who in the late 1880s would not have anything to do with the Catholic hospital in Helena, Montana, even though their family physician was on staff at the hospital.

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[24] Slayton diary, 4 March 1927. The exact nature and purpose of this procedure remains in question.
[25] Slayton diary, 23 March 1927.

Daniel may have made the decision to go to Great Falls on his own given that he was having no success with other methods, but it was more likely that he was referred there to see a specialist for diagnostic tests. Perhaps Dr. Armstrong, himself a strong Episcopalian, preferred to send his patients to a Protestant hospital. Whatever the circumstances of his admission, Daniel's tests while in hospital included multiple x-rays, as well as blood drawn from his ear for a "test of some kind."[29] After two days in hospital, Daniel was annoyed to learn that Dr. Porter, the "bone man," had gone to Helena and he was unable to learn what his x-rays had shown.[30] On his fourth day in hospital, he had three more x-rays.[31] On the 10th, he noted, "lots of visitors today and the doctors on the jump, could not find out anything more but Dr. thought I could go tomorrow." The next day Daniel was discharged from the hospital having "finally" been told the sad news that he had bone cancer and that the Great Falls doctors believed that there was nothing more that could be done for him.[32]

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[26] Quoted in Leland P. Cade, *Golden Valley County*, 159.
[27] "News of Lavina," *Roundup Tribune*, 28 December 1922, "News of Lavina," *Roundup Tribune*, 14 December 1923.
[28] A son was born to Daniel and Lizzie's daughter Ruth and her husband Vern. Slayton diary, 19 April 1926.

Living with Dying: The Early Terminal Phase

Historian Gerda Lerner, in a poignant chronicle of her husband Carl's decline and death from brain cancer in the early 1970s, suggests that a terminal diagnosis can sometimes set patient and family members on a path of psychological separation from one another. Following Carl's diagnosis and subsequent brain surgery, Gerda began to prepare herself for his death, and to help him to die a "good death." Carl's primary focus became to survive, to live.[33] The same phenomenon may have existed for the Slaytons. Although available sources provide little information about how his family reacted psychologically to his terminal diagnosis, Daniel's diary entries following his diagnosis show him squarely focused on living life as normally and fully as possible. Immediately following the sentence that he recorded on April 11 stating that the doctors had told him that he had bone cancer and there was nothing that they could do for him, he wrote in his diary that he paid his bill at the hospital, got a ride to town, and "got shaved."[34]

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[29] Slayton diary, 6 April 1927.
[30] Slayton diary, 7 April 1927.
[31] Slayton diary, 9 April 1927.
[32] Slayton diary, 11 April 1927.
[33] Gerda Lerner, *A Death of One's Own* (Madison: University of Wisconsin Press, 1985), 49.

The doctors in Great Falls considered Daniel's case to be hopeless, but in the immediate aftermath of his diagnosis, Daniel sought a more optimistic outlook for his future. He was willing to go to any length or travel any distance if it meant one last chance at survival. On his fifth day home he composed a telegram to send to "Rochester" about his case.[35] The following day he received a wire back from the Mayo Clinic "to come."[36] That evening he "had a bad night but took dope" and rose early in the morning so that he, Lizzie, and their youngest son Ernest, could board a train headed for St. Paul with a connector to the Mayo Clinic in Rochester, Minnesota.[37]

A trip to the Mayo Clinic was an arduous journey for a patient with cancer. The threesome spent over a day and a half on trains, with Daniel describing part of the trip as "a very rough 93 mile ride thru a farm country dotted with big and red barns."[38] When they arrived in Rochester, the Slaytons booked into a hotel that ran a free bus service to the clinic. Daniel was impressed with the "new" Mayo Clinic, which stood at 11 stories of steel in the early stages of concrete pouring. He had a brief interview with a physician on his first day and the next day was subjected to a battery of testing which included blood tests, x-rays, nose, throat and ear checkup and a rectum exam by three doctors. No small wonder that he wrote in his diary that he was "pretty well used up" after such an exhausting day.[39] The next morning a "new" doctor worked on him "a little" before he was informed that he could return to Lavina.[40] He left the next day having been advised that a report of their findings would be sent to Dr. Armstrong in Billings, which suggests either that Dr. Armstrong referred Daniel to the Mayo Clinic, or that doctors preferred to report to other doctors, even if a patient initiated the visit.

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[34] Slayton diary, 11 April 1927.
[35] Slayton diary, 15 April 1927.
[36] Slayton diary, 16 April 1927.
[37] It is not clear what type of "dope" Daniel took the night before he left for Rochester, but it was likely pain medication, perhaps even morphine. Slayton diary, 17 April 1927.
[38] Slayton diary, 18 April 1927.

As with others before him, Daniel's trip to Rochester served as confirmation that his cancer was terminal. On May 1 Daniel received a letter from Dr. Armstrong, presumably the letter that the Mayo doctors had promised. Although he did not reveal the precise contents of the letter in his diary entries, nearly a week after receiving the letter he wrote to his friend Tom Marlow and "told him of my condition."[41] In his correspondence with Tom and several other friends, Daniel must have conveyed the seriousness of his condition for within days he received "a sympathy letter from Tom Marlow and another from Mary Carew."[42] He also wrote a long letter to his eldest son Dan, who lived in California, several to his siblings back in Virginia, and one to his sister Dollie who was herself seriously ill and being treated at the now infamous Battle Creek Sanitarium, at Battle Creek, Michigan. Some months later, when his cancer was in full swing, he received a letter from Dollie's nurse at Battle Creek along with brochures detailing the medical services provided at the sanitarium.[43] Although Daniel never visited the Battle

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[39] Slayton diary, 19 April 1927.
[40] Slayton diary, 20 April 1927.
[41] Slayton diary, 7 May 1927.
[42] Slayton diary, 10 May 1927.
[43] Slayton diary, 11 August 1927.

Creek facility, he may have been familiar with its services before he read about them in brochures. Daniel subscribed to some aspects of the recovery regimen that Dr. John Harvey Kellogg promoted at the sanitorium, including sunshine, fresh air, and electrical stimulation.[44]

From April until mid-August 1927 Daniel bore his illness stoically, retaining control of his body, his cancer, and his life. Up until his final month, he continued to participate in family and ranch life, finding solace and comfort in his family and in his ability to keep up his regular habits of walking or riding to town to attend to business, socialize or indulge in frequent visits to the barber. He spent a good deal of time getting his legal and financial affairs in order, including cleaning out his home desk during the last week of May.[45] Through all this time, he was also dealing with a foreclosure case related to one of the banks in which he held a controlling share.[46] Although the social and business consequences of his expected demise occupied a good deal of Daniel's time, it was the physical manifestations of the disease that required constant attention.

Daniel dealt with his physical symptoms in much the same way that he had faced them prior to the terminal diagnosis. Daniel himself largely managed his own palliative care for many months. As he had previously, he depended upon the methods of "medicine by mail," and treatments with electricity. However, he began to depend less upon wet heat applications or sweat blankets, and took up sunbathing instead.[47] Although sunbathing had long been understood to have health benefits, the practice was enjoying widespread popularity during the 1920s, thanks in part to its promotion as part of a health system that American muscleman Charles Atlas had been advertising since the 1910s. [48]

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[44] Patsy Gerstner, "The Temple of Health: A Pictorial History of the Battle Creek Sanitarium," *Caduceus: A Humanities Journal for Medicine and the Health Sciences* 12, no. 2 (1996): 1-99.

[45] Slayton diary, 24 May 1927.

[46] Slayton diary, 29 April and 9 May 1927.

[47] Slayton diary, 19 and 20 July, 4 August 1927.

Daniel relied heavily upon the United States postal service for what was perhaps the most important element of his self-care—drugs. He and Dr. Armstrong continued their running correspondence, with Daniel writing often, sometimes to ask for advice but most often to request medicine, likely painkillers. As he had in his offices, Dr. Armstrong tended to keep Daniel waiting. On June 6 Daniel wrote, "Did not hear from the Dr. and went without any medicine." The next day he had his daughter Ruth phone Dr. Armstrong "again" and Dr. Armstrong "promised to mail medicine promptly."[49] Perhaps he was just being hard to please, but the following day Daniel complained, "got some new medicine but no letter."[50] Even as he grew weaker, Daniel tried to stay involved in and direct efforts related to his medical care. Although he no longer wrote in his diary after August 20, he did muster the required strength to write to the Mayo Clinic on August 23 for "information on what to do to help him." Five days later he wrote the last letter that he would ever write and sent it to Dr. Armstrong, the final installment of a six-month correspondence that was a crucial element in Daniel's self-care. That same day, he asked his cousin Mary to write a letter to the doctors in Great Falls.[51] Lizzie's entries in his diary do not mention the receipt of replies to any of the letters he sent.

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[48] Elizabeth Toon and Janet Golden, " 'Live Clean, Think Clean, and Don't Go to Burlesque Shows': Charles Atlas as Health Advisor," *Journal of the History of Medicine and Allied Sciences* 57, no. 1 (2002): 39-60. Mary Baker Eddy was one of several nineteenth-century health reformers who subscribed to sunbathing. Stephen D. Fox, "Healing, Imagination, and New Mexico," *New Mexico Historical Review* 58, no. 3 (1983): 213-237.
[49] Slayton diary, 7 June 1927.
[50] Slayton diary, 8 June 1927.

As time and his cancer advanced, Daniel became increasingly less mobile and more dependent on those around him. He tried to work in the garden or barns but made repeated references to not being able to get much done. July 14 appears to be the last day that he left his home. On that day he rode to town to pay some bills and then he "visited some."[52] On July 20 he "suffered more than usual with my leg" and by July 30 he wrote "have had a lot of misery today."[53] By that time, the barber was making house calls to the Slayton home, and Daniel's daily physical activities were more or less restricted to taking sun baths on the porch, snapping beans and shelling peas, and sitting up to receive visitors. On August 8 he had two of his associates from Slayton Mercantile witness his will, signaling his awareness that the end was growing near. In the following week his condition worsened considerably, and on August 19 Lizzie added a few brief sentences to Daniel's own final diary entry. [54]

The Dying Time: The Late Terminal Phase

The shared experience and intense emotions associated with the death of a loved one were symbolized in the diary on August 20 when Daniel's wife Lizzie took over recording the daily entries at the same moment that Daniel made the transition from caring for himself to being cared for. This date marks the beginning of the end of Daniel's fight with bone cancer.

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[51] Slayton diary, 28 August 1927.
[52] Slayton diary, 14 July 1927.
[53] Slayton diary, 20 July and 30 July 1927.
[54] Slayton diary, 8 August 1927, 19 August 1927.

Daniel's caregivers had no way to predict how long he might linger but as he grew weaker and his pain intensified, they must have perceived that the end was nearing. A pattern of events starting on August 20 reveal that Lizzie and others expected that Daniel was at a point in his illness where he would only worsen. An understanding of the parameters of Daniel's dying trajectory is possible because of his diary, and especially because of Lizzie's entries in it. The fact that on this date Daniel ceased to write anything more in the diary that he had kept since 1884, the year that he arrived in Montana, was just one indication of his obvious decline. This was also the date that the eldest son, Dan Jr., was called and asked to return to Lavina from California. It also marked the first night that family members began to keep a nightly vigil at his bedside. Usually one of Daniel's grown children stayed with him, along with his 60-year-old cousin Mary Sagar. [55] The practice of "night sitting" meant somebody was available to provide whatever practical or physical assistance the dying person might require during the night. It also provided a psychosocial element of care that ensured that the dying person would not be alone in their final moment of life.[56] Sheila Rothman, in her study of tuberculosis, identified people who sat up with the dying in the nineteenth century as "watchers."[57] Similiarly, Emily Abel found that women often sat up with dying neighbours as part of a large female network that shared services at times of birth, illness and death.[58] From August 20 until the day of his death, at least one and usually two people night-sat with Daniel.

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[55] Daniel's diary notes that his cousin Mary moved into his house in June although it is not clear whether she did so for financial reasons or for health reasons. She had been ill during the spring with some unnamed affliction. It is also possible that she moved into the house to be of assistance to Daniel. Slayton diary, 11 June 1927.

[56] British nurse Harriet Copperman explains that "A night sitter for the last few nights will often mean the difference between the patient dying peacefully at home with a satisfied family, or being bundled into hospital and perhaps dying within 24 hours, leaving a guilt-ridden family." Harriet Copperman, *Dying at Home* (Chichester and New York: John Wiley & Sons, 1983), 79.

In *Reading Between the Lines*, Betty Jane Wylie argues that, historically, female diarists "are not silent about death in their midst." Rather, women "report with precise detail the last days, hours, and minutes of a family member's death and the care involved."[59] Although Abel found that "women's writings often omitted the physical details of sickness," this was not the case in the Slayton diary.[60]

Lizzie kept close watch on Daniel's biological functions, as if she were aware that his body was shutting down. From the first, physiological issues dominated Lizzie's entries, which was not surprising given that it was Daniel's physical care that most occupied the household during that time. On August 20, Lizzie made her first full diary entry, writing in Daniel's voice, as if he dictated it:

> Pleasant and hot day. Same men haying with Richard Griffin helping. Sent for Dr. Firey who got here about 10 AM. He gave me some powders for my bowels to take at 1:30 and 3:30 PM. Also to use glycerine

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[57] Sheila M. Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (New York: Basic Books, 1994), 8.
[58] Abel, *Hearts of Wisdom*, 17.
[59] Betty Jane Wylie, *Reading Between the Lines* (Toronto: Key Porter Books, 1995), p. 105.
[60] Abel, *Hearts of Wisdom*, 55.

> suppositories and olive oil to inject in rectum. His bill $25 which is not paid.

Just as Daniel often mentioned the cost of things in his diary, Lizzie also painstakingly recorded the cost of most purchases in her entries. For some people, notations pertaining to household expenditures would have been part and parcel of keeping a daily chronicle, but given the family's recent bankruptcy situation, it is also possible that both Daniel and Lizzie were worried about monetary issues. If Lizzie was generally prone to worrying about financial matters, the fact that Dr. Firey's account went unpaid probably caused her stress that she could have done without.

Dr. Firey was called in response to Daniel's worsening physical state. It is impossible to determine what the doctor's assessment of Daniel's condition was on that day, but it must have been grim. There was a decided acceleration in the level of care being delivered from the time of Dr. Firey's visit forward, but it was nursing care, not professional medical care that came to dominate the sickroom. Indeed, almost all of the care that Daniel received over the next three weeks was delivered by a small number of informal caregivers and one formal caregiver, all of whom were women. At different times, one or more of his two daughters, two daughters-in-law, and his cousin Mary were available to provide care. But the most visible and instrumental caregivers over the course of Daniel's dying time were his wife Lizzie, a midwife Eunice Randall, and Miss O'Day, a private-duty nurse from Billings.

As Daniel's spouse, Lizzie earned the title of primary caregiver, although her personality, age, and her own health problems influenced the type of caregiving activities that she could take on. Reading Daniel's diaries leading up to 1927 one might have expected that Lizzie was the most likely member of the Slayton family to face a health crisis. In addition to suffering acutely with rheumatism, she generally had "a hard time with sickness in one way or another."[61] At the advanced age of sixty-nine, Lizzie's frailness seemed quite apparent, and she did not generally participate in everyday household chores. For instance, when Daniel had been well enough, he was the one who prepared all of the meals for his haying crew, and when he was incapacitated other relatives or friends pitched in to get food on the table. By most accounts, Lizzie spent little time in the kitchen. A man who had worked as a foreman for a haying crew at the Slayton ranch during 1927 remembered her as "high class stuff."[62] Lizzie did not need to engage in much physical labour in her home. Her daughters, daughters-in-law and granddaughters helped both inside and outside of the house. Despite their financial difficulties, for years the Slaytons had paid to have someone come in and do laundry once a week. Perhaps in anticipation of things to come, at the end of April they hired a young girl to live in and help out with household chores.[63] Although Lizzie did not provide the lion's share of physical care, the psychosocial and spiritual support that she rendered to her husband was just as essential. With the practical dealings of the household taken care of, Lizzie was free to provide the loving care that only a partner of so many years could.

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[61] Letter to Daniel W. Slayton from A. Martin, n.d., Folder 8, Box 1, Daniel Webster Slayton and Lizzie Ellis Slayton Papers, Montana Historical Society Research Center, Helena, Montana.

[62] The foreman also recalled: "I didn't see Lizzie very often. She didn't want to associate with the working man." Cade, *Golden Valley,* 224.

[63] Slayton diary, 28 April 1927.

She could fix his tea or coffee as he liked it, read to him, or simply chat with him about events unfolding outside of the sick room.[64]

Another of Lizzie's foremost activities was to complete the chronicle of Daniel's life by recording his dying narrative. Daniel was obviously a devoted diary keeper, and Lizzie understood the import that Daniel attached to the small leather volumes that held the story of his life.[65] As a record keeper at the bedside, Lizzie did an outstanding job. She made note of the many treatments administered and recorded daily the physiological details of his failing condition as though she were a professional nurse trained in the art of chart-keeping. For the first several days that she wrote in the diary, Lizzie had retained Daniel's voice, perhaps hoping that he would step back in and take over the diary. Later, she switched to the third person, a symbolic, although likely subconscious, indication that she knew that his days of speaking and writing for himself were nearly done.

The most compelling evidence that women knew what to watch for in a dying person and what to assist with comes from the Slayton diary.[66] Lizzie's entries make clear her knowledge about terminal care. Physical details that Lizzie remarked upon as she cared for Daniel in his final days suggest that she knew signs to watch for when a person was approaching death. Specifically, she referred to Daniel's "legs getting cold,"[67] to his "urine gradually stopping,"[68] and in the final days, to his sleeping "most of the time."[69] All of these are physiological signs of impending death; all are listed as signs of imminent death in modern manuals written to help families who are caring for a terminally ill person.[70] What the Slayton diary does not explain is exactly how Lizzie Slayton learned how to interpret these signs. She could have been alerted to what to watch for from a physician, a midwife, or a trained nurse, all three of whom were involved in some capacity with caring for Daniel Slayton during his final days. Nothing in the diary suggests this, however.

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[64] Copperman, *Dying at Home*, 1.

[65] Lizzie started keeping her own diary in 1917 but discontinued the practice in 1918. Raising five children likely consumed much of her free time. Quite remarkably, making Daniel's final entries motivated her to take on Daniel's role as family chronicler for several years. She continued to write daily in Daniel's 1927 diary and in the new year she started a fresh, new diary and continued to diarize until 1934. Her daily writings continued to be short and to the point. Lizzie died in 1940 at the age of eighty-two. "Funeral for Lizzie Slayton, Early-Day Montanan, Is Friday," *Roundup Record-Tribune*, 25 July 1940.

[66] Daniel Slayton diary, Daniel Webster and Lizzie Ellis Slayton Papers, Montana Historical Society Research Center, Helena, Montana [hereafter Slayton diary].

Much of the bodily care that Lizzie narrated during Daniel's final weeks was provided to Daniel first by Eunice Randall, Lavina's local midwife. Eunice Randall was mentioned frequently in Daniel's diary pages as a household visitor before he became seriously ill. Eunice appeared to be more than a casual acquaintance, but not as close a friend of the Slaytons as a number of other Lavina adults. When Eunice arrived at the Slayton home on August 20, the day that he took a turn for the worse, she came not as a friendly visitor, but to offer her assistance as a knowledgeable caregiver:

> Eunice Randall came to help and gave me injections of olive oil and epsom salts, which helped to clean out the lower bowel. The Dr. sent up some mineral oil to take when cleaned out. Laid abed all day. Lydia

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[67] Slayton diary, 25 August 1927.
[68] Slayton diary, 29 August 1927.
[69] Slayton diary, 6 September 1927.
[70] Joan Furman and David McNabb, *The Dying Time: Practical Wisdom for the Dying and Their Caregivers* (New York: Bell Tower, 1997), 131-132.

> canned her blackberries here in afternoon and here again for the night with Mary helping to take care of him.[71]

It is not known whether Eunice Randall regularly aided with care of the dying in Lavina, but the fact that she continued to be called to the Slayton home suggests that they relied upon and trusted her gifts and abilities as a nurse and healer. On August 22, Lizzie wrote:

> Eunice came. Gave Pa niter and a mustard poultice on his back. Had some bowel passage just as she came. Can't pass but little urine. Put hot cloths on bladder and took pumpkin seed tea. [72]

Knowledgeable about a wide range of home care remedies, Eunice administered more therapeutic treatments than any other caregiver on Daniel's caregiving team. She provided the most personal aspects of physical care when she administered enemas of Epsom salts and olive oil, or Epsom salts and water. The mustard poultice that she applied was a common treatment for respiratory ailments, including pneumonia, an expected outcome of terminal cancer. Pumpkin seed tea was believed to contain medicinal properties that helped improve bowel function by ridding the intestinal tract of parasites and worms. Finally, "niter," also known as spirit of nitrous ether, was a pale yellow liquid obtained by the distillation of alcohol with nitric and sulphuric acids. It was used as a diaphoretic or, as in Daniel's case, an antispasmodic or diuretic. In a later entry, Lizzie refers to Eunice administering half a teaspoon of niter in water to Daniel.[73]

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[71] Slayton diary, 20 August 1927.
[72] Slayton diary, 22 August 1927.

Daniel's condition worsened daily, and somebody in the household once again determined that the doctor needed to be called. Although Lizzie made no reference to it in the diary, the "Lavina News Notes" column of the *Roundup Record* stated that Dr. Firey attended at the Slayton home August 25.[74] All indications are that this was the first and last time that a physician visited the Slayton home during Daniel's dying trajectory. Although after 1950 the physician would come to hold a central position at the bedside of the dying, in the 1920s in North American history the doctor appears to have done little more than confirm that all medical efforts had been exhausted, and perhaps prescribe palliative drugs.

Only a few historians have looked at the topic of the role of the physician in tending to the dying. Sheila Rothman and Pat Jalland both found that although doctors ceased providing medical treatment at a certain point in a patient's dying trajectory, physicians often remained at the deathbed. In Rothman's study, in a chapter on the mid-to-late nineteenth century, physicians remained at the bedside even after they gave up actively treating tuberculosis sufferers. Family members found physician efforts to provide moral support to patient and family was an acceptable replacement for the absence of curative medical treatment. As long as physicians showed compassion and caring, they remained part of the caregiving team.[75] Similiarly, Jalland argues that despite their limited therapeutic powers, Victorian doctors played an important role in end-of-life care by providing "a remarkably good record of terminal care, comfort, and palliative management."[76] Jalland and Rothman both show that physicians knew that they had additional roles to play beyond treating the patient's disease, and they acted accordingly, often at the patient's or family's insistence. In concert with informal caregivers, they provided a holistic program of care to the dying, a program that included spiritual and psychosocial, as well as physical care.

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[73] Slayton diary, 29 August 1927.
[74] Slayton diary, 25 August 1927.
[75] Rothman, *Living in the Shadow of Death*, 114-115.

Evidence in the Slayton case study suggests something quite different—namely that the physician was completely absent during the final days of the dying trajectory. In Daniel's case, doctors played only a minimal role in the late terminal phase. One can speculate about the reasons why. The doctor's short and infrequent visits might have been typical for a rural community, especially in a small town like Lavina which was without its own local physician. Perhaps the Slaytons were unwilling or unable to pay for the doctor to come more often, or to stay for longer periods of time. It is also possible that by the late 1920s the "house call" was gradually becoming something of a lost art, and that what transpired with respect to physician attention in the Slayton household was quite commonplace. More research into the role of the physician in care of the dying ought to be undertaken.

The Deathbed: Intensive Caregiving

As the final days of August came to a close, the Slayton family faced several more critical junctures related to Daniel's dying trajectory. On August 27 Dan Jr. arrived from California, and Eunice Randall came "to stay for a few days." Then, on August 31 Lizzie wrote:

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[76] Pat Jalland, *Death in the Victorian Family* (Oxford, England, and N.Y: Oxford University Press, 1996), 77.

> Pleasant. Pa very nervous. Didn't sleep much of any and Ernest called me and I gave him some medicine, then he wanted the rest called and Dan came in and we had a very serious talk and we crossed hands and he promised to look after me and do right. Ruth came in, then Mary, and then Lydia, Bert and Pearl.[77]

Daniel's decision to call his family to his bedside signaled his awareness that time was running out. As a devoted husband, his main concern was to secure a promise from his eldest son to take care of Lizzie after he was gone. Although his tiredness must have made the effort difficult, he felt it was time to say what he had to say to his children, his cousin, Mary and one of his daughters-in-law, Pearl. By the end of that day, any doubts his family had about the reality of his impending death were surely erased.

Another event on the 31st that signaled the seriousness of Daniel's condition was Dan Jr.'s decision that a trained nurse needed to be "sent for." Perhaps Dan felt that the care that Eunice Randall was providing was inadequate, or perhaps Eunice was unable to continue her bedside care due to other obligations as she did have a young son at home and babies to deliver. A call was made to Dr. Armstrong, who advised that Miss Harriet O'Day, a private-duty nurse from Billings, would be available to tend to Daniel. [78] A son-in-law was dispatched to pick her up. Whether he had to drive to Billings or merely to the train station in Lavina is not clear. Upon her arrival, Miss O'Day gave Pa some "pain medicine," almost certainly morphine, which "kind of upset him and he was a little out of his head." Lizzie "was called" at 11:00 pm. The reference to being "called" might have meant that the nurse thought Daniel was about to expire, or Daniel himself could have been calling out Lizzie's name. [79]

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[77] Slayton diary, 31 August 1927.

[78] Although there is no evidence that the Slaytons had ever met Miss O'Day, she obviously bonded with Lizzie during this difficult time. On a trip to Billings several months following Daniel's death, Lizzie telephoned and then visited with Harriet O'Day for the afternoon. Slayton diary, 3 November, 1927.

The arrival of a professional nurse was an addition to, but not a replacement for, family care. Family members continued to sit with Daniel at night and during most hours of each day. Lizzie continued to record the details of Daniel's care, noting the precise times at which Miss O'Day gave him "a hypo," or hypodermic injection. On September 2, the morphine "made him dozey," but he had a "very bad spell" between 1:00 am and 3:00 am and another "towards morning." Lizzie wrote, "could hear him from my room."[80]

Another crucial turning point came on September 3 when Daniel "called for Mr. Peck." Reverend Peck, the Methodist minister had been a welcome guest in the Slayton home for several years, but the number of his visits had increased following Daniel's terminal diagnosis. During June he made one visit, during July three. On August 8 Reverend Peck visited the same afternoon that Daniel had his will witnessed, and he called again on August 21 just as Daniel's condition was worsening. Reverend Peck's last visit with Daniel took place on the 3rd, the last day that Daniel appeared to be coherent. Lizzie wrote, "He called for Mr. Peck and when he came he talked with him and then we had a word of prayer together."[81] Having settled business and family matters, his last words were directed to settling affairs with his God.

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[79] Slayton diary, 31 August 1927.
[80] Slayton diary, 2 September 1927.

During the final week of Daniel's life, the household beyond the death chamber remained a hub of anxious activity, the stresses of caregiving exacerbated by the heightened level of activity. The social reality of Daniel's dying trajectory was that it took place in a very full and busy household, and it coincided with one of the busiest times of the ranching year. In addition to having to feed a haying crew of ten people, on September 4 the Slayton family had to welcome their annual boarders. Daniel and Lizzie had provided living accommodations for Lavina's school teachers for many years and even though their arrival meant more work at this already frantic time, they did not turn the teachers or their high-school boarder away.[82] Besides Daniel, Lizzie, and Mary Sagar, the ranch foreman and the hired girl lived-in, so with the addition of four new boarders and a nurse the population of the household grew to ten persons living under one roof. In addition, the Slayton's five adult children, their spouses, and multiple grandchildren were in and out of the house daily. Mealtimes alone were a major undertaking since with the haying crew, more than twenty people had to be fed at each meal.

Events taking place in the Slayton home during Daniel's final weeks of life reveal how willing Lavina community members were to pool their resources to assist a family in need. While friends from church, the Eastern Star, and the Ladies Aid dropped by with flowers, berries and tumblers of jelly, other women provided support of a more practical nature by helping to cook dinners. Male friends also showed up. George Hogan came to deal with a swarm of bees on Lizzie's Russian Honeysuckle and other friends dropped in to visit Daniel.[83] August 28 was the last day that Daniel received visitors. On that day he met with Mr. Moreland for a few minutes, but did not want to see Gertrude Fisk or Mr. Cooper. During his last week of life, Daniel did not receive social callers.

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[81] Slayton diary, 3 September 1927.

[82] The money would have been a factor, in that the teachers each paid a monthly amount for their room and board.

According to Lizzie, Daniel had one of his worst spells on the night of September 4. As she wrote: "He was out of his head most of the time and also thru the night, getting worse, weaker, and more flighty." By now, the physical and emotional strain was starting to show on everybody, especially Lizzie.

> A fine morning. I had a bad spell myself from being worn out and getting a big store bill $244. It discouraged me so I played out and laid on bed all morning. In afternoon felt better and took a walk down to the wheat field and saw Kenneth cutting wheat and Dan Jr. shocking it. Bert and Eunice and Pearl and Ernest down at night and Ernest staid in the room with him all night. [84]

The bad nights did not subside and Lizzie grew even more exhausted. On the day before he died, Lizzie observed that Daniel was very restless, with "arms agoing all the time but he doesn't call for us so much." That evening, she "heard Pa in the night and partly dressed but as I was not called laid down again in bed with shoes on." Daniel also did not eat or drink on that day; the end was fast approaching. Ernest, the youngest Slayton son, stayed with Daniel for most of the night. [85]

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[83] Slayton diary, 22 August 1927.
[84] Slayton diary, 5 September 1927.
[85] Slayton diary, 7 September 1927.

In Daniel's final hour, nurse O'Day watched over Daniel's dying body as the devout Lizzie drew heavily upon her faith to perform her final and most important caregiving task, to help Daniel make the spiritual transition from this life to the next. Strong spiritual faith had woven its way through the fabric of Daniel and Lizzie's lives, and in his final weeks, days, and hours, religious sentiment climbed to new heights. Lizzie was obviously familiar with traditional religious rites and rituals at the deathbed, as evidenced by her choice of Psalm and hymn. But religious fervor was employed only in part as a religious ritual to escort or encourage Daniel's spirit out of the material world. Standing beside Daniel's deathbed, Lizzie engaged passionately with her faith as a means to get herself and her children through the wrenching agony of losing her beloved husband and their father. One can almost feel the depth of Lizzie's emotions as she stood over her dying husband reading the 103 Psalm, a psalm of thanksgiving and joy that acknowledges the finite days of humans. From verses 15 and 16:

> As for man, his days are as grass; as a flower of the field, so he flourisheth.
> For the wind passeth over it, and it is gone; and the place thereof
> knoweth it no more. [86]

Following Lizzie's spiritual ministrations, Miss O'Day also said a short prayer, which was followed by the family's recitation of the Lord's prayer. Sometime later, Reverend Alstad, the local Lutheran pastor, attended the deceased to pray and read from the New Testament. Reverend Peck's absence is explained by a newspaper article noting his departure for Bozeman to attend the Methodist conference.[87] The long nights of torturous agony were over for Daniel, but with his death his family's pain and grieving was newly born.

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[86] Slayton diary, 9 September 1927; Psalm 103: 15-16.

The Slaytons did not have to bear their sorrow alone. In the days following Daniel's death, the community of Lavina supported the family as they had throughout Daniel's dying days, a reminder that the acts of death and dying have social implications. On the day of Daniel's death, the school flag was dropped to half-mast and the general store that he had previously owned was closed, to honour a leader of the community. Mrs. Jensen brought doughnuts, Mrs. Bilden and Mrs. Balgord, long-time Slayton friends, dropped by to offer sympathy and help where needed. Mrs. Linton, Miss Gossink, and Mrs. Burdick each took one of the three teacher-boarders back to their homes to provide them with an evening meal.[88] On the following day, there was a nearly full-page obituary for Daniel in the *Roundup Record* on the front page, stating that news of this pioneer's demise had "caused profound sorrow among his host of friends" even though "it was known for some months that his condition was hopeless."[89] Daniel's status in the community was likely what garnered extra concern for him and his family from non-family members. In terms of providing physical and psychosocial support, the women of Lavina had more than done their part and would continue to do so as the grieving and funeral process wore on.

Conclusion

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[87] *Roundup Record*, 9 September 1927. Although the article was published two days after Daniel's death, the news would have been from earlier in the week.
[88] Slayton diary, 8 September 1927.

Lizzie Slayton's daily record of Daniel's dying trajectory provides a window into one family's experience with care of the dying and provides important insights into the history of the home as hospice. Overall, what this case study makes apparent is that the process of dying and caring for the dying was not treated solely as a medical event. Tending to Daniel's physical needs and comforts took up a great deal of time in the late terminal phase. At the end, a large cast of characters participated in the unfolding drama in the Slayton household, tending variously to the physical, practical, religious, and psychosocial needs of both patient and caregivers.

The team that tended to Daniel consisted primarily of females, some of whom were close relatives, while others entered the household specifically because they had the skills required to care for a critically ill person. Daniel's sons were known to sit and visit with him during the daytime and sometimes through the night, but there is no evidence that they provided any physical caregiving. Dan Jr. assumed an authoritative role when he arrived in Lavina from his home in California. As the eldest son, perhaps it was expected that he would take charge when his father was incapacitated. Clearly, he was the person who decided that it was time to hire professional nursing services. Harriet O'Day's arrival in the household did not seem to disrupt in any way the caregiving routines and regimes that had been put in place during the weeks that Eunice Randall, Lavina's midwife had provided the nursing care.

How much the Slayton case study is representative or typical of families in the region is hard to ascertain. The Slaytons were elite members of a small community and the amount of care available to Daniel and his family reflected his status. Like the Fergus

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[89] "Death Claims Dan Slayton, Mont. Pioneer," *Roundup Record*, 9 September 1927.

family and its experiences with Pamelia's terminal cancer forty years earlier, the Slaytons were icons in their community. Although Daniel had fallen on hard times financially, he still had the means to travel as often and as far as he wanted to in order to seek medical treatment. His story illustrates how patients decided for themselves how far to go for treatment. Daniel traveled out of state, whereas forty years earlier Pamelia Fergus decided to leave her trust in the hands of Montana physicians. In the end, when treatment options were exhausted and the real work of dying began, family care, with some help from outside the household, allowed these two Montanans to die at home. To modern readers, there is a sense of success in Daniel's death. He died at home, in his own bed, surrounded by the people and the things that he had loved and worked for.

CHAPTER SIX

Conclusion

Gary Laderman's reflections on the medicalization of death and dying in today's society provide a troubling reminder of how inadequately North Americans deal with death, an event which we know is natural and inevitable:

> When death occurs, it usually takes place and is officially announced in a medical setting. The individual presiding over the transition from life to death is the doctor, who reads the body with an assortment of technological devices to make sure that there are no positive signs of animation.[1]

Despite the emergence of hospice and palliative care as a specialized field over the past four decades, death today often occurs precisely as Laderman has described. Although medical science deserves praise for its many advances over the past century or so, the ways in which professional medicine has transformed care of the dying is in many ways appalling.

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[1] Gary Laderman, *The Sacred Remains: American Attitudes Toward Death, 1799-1883* (New Haven: Yale University Press, 1996), 2.

In North America, largely as a result of the swelling numbers of hospital deaths, concerns about care of the dying have become increasingly evident in the political, medical, and cultural milieux of the late twentieth century and early twenty-first century. In October 1999, Ira Byock, a hospice physician from Missoula, Montana, testified before the United States House of Representatives Committee on Government Reform. Passionately committed to the plight of the dying, Dr. Byock appealed to the committee, stating that "there is no greater urgency facing American society than relieving the crisis that surrounds dying and care for the dying in our country." Furthermore, he argued, "dying patients and their families have known this for a long time."[2] In Canada in June 2000, a Senate Subcommittee made a similar plea in its report, *Quality End-of-Life Care: The Right of Every Canadian.*[3] The subcommittee found that terminal care for Canadians remained wrongly focused on hospital care and that the burden of care in the community and the home too often fell to individual family members, primarily women. Already, at the beginning of the twenty-first century, problems related to the care of dying cancer patients are considered to be at a crisis point, and that crisis is growing.

Although the politicization of care of the dying emerged in the late twentieth century, concerns about where terminal care ought to be provided and by whom have preoccupied many patients, families, physicians, and health policymakers for at least the past century. Alberta and Montana sometimes took different approaches in developing hospitals, sanatoria, and other health care programs, some of which aided the dying. However, it is clear that up until at least 1950, regional similarities were more significant than national differences when it came to care of the dying. The border did not delineate differences for the terminally ill. In Montana, federal initiatives created change, whereas provincial initiatives from the United Farmers of Alberta and the Social Credit governments, in particular, created change in Alberta. However, between 1880 and 1950 doctors and government officials dealt with similar problems and the experiences of terminal illness from patient and family perspectives were remarkably similar. Like most Canadians and Americans, Albertans and Montanans viewed care of the dying as a private family matter to be handled in the home, not a public health or medical matter requiring government support. Yet, various health care institutions faced the issue of when and how to provide terminal care to those without nearby family members.

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[2] Ira Byock, "Improving Care at the End of Life with Complementary Medicine," Testimony presented before the Congress of the United States, House of Representatives, *Dying Well Organization*, http://www.dyingwell.com/uschrtest.htm/, accessed 24 October 2004.

[3] Subcommittee of the Standing Senate Committee on Social Affairs, Science and Technology, "Final Report: Quality End-of-Life Care," *Parliament of Canada, 36th Parliament, 2nd Session*, http://www.parl.gc.ca/36/2/parlbus/commbus/senate/com-e/upda-e/rep-e/repfinjun00-e.htm/, accessed 24 October 2004.

The fact that there were significantly more men than women in Montana and Alberta for most of the period examined in this study led at least a portion of the unmarried men to die in hospitals. Different demographic situations, especially the lack of kin resources and skewed sex ratios, forced hospitals to address the specific needs of their communities. The important role of family is clearly delineated by the fact that it is the absence of family that can guide or transform the types of services that hospitals provide. In that regard, the emergence and development of the small female proprietary hospital is a phenomenon that must be explored further. The historical record will be greatly enhanced if more can be learned about why and where these institutions flourished.

This dissertation grew out of frustration with literature in the history of health and medicine that implied that families readily gave up their caregiving role once hospitals became available. Evidence from the history of Alberta and Montana contradicts this assumption. Terminal care in hospital was the exception and not the rule. Families did not abdicate their responsibilities for the dying. Instead, family members continued to provide care to dying loved ones up to at least the middle of the twentieth century.

Viewing the history of care of the dying through the lens of family highlights the importance and influence of gender in the provision of terminal care. Regardless of whether terminal care took place at home or in the hospital, women provided most of it. Further research is needed on how women acquired and passed on the knowledge of how to care for the dying. As is the case today, the availability of a female caregiver influenced both the level of care that the dying would receive and the location where that care would take place.[4]

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[4] In this study, I was able to confirm what Susan L. Smith and I had suggested in an earlier essay, namely that the availability of a female caregiver was a key determinant of where terminal care took place. Susan L. Smith and Dawn D. Nickel, "From Home to Hospital: Parallels in Birthing and Dying in Twentieth-Century Canada," *Canadian Bulletin of Medical History* 16, no. 1 (1999), 57. Vincent Maida claims that currently the presence of more than one caregiver is a factor that promotes success in home palliative care. Vincent Maida, "Factors that Promote Success in Home Palliative Care: A Study of a Large Suburban Palliative Care Practice," *Journal of Palliative Care* 18, no. 4 (2002): 282-286. Audrey W. M. Ward similarly found that the degree of help available to caregivers was the major factor that determined whether a patient died at home during the early 1970s in Sheffield, England. Audrey W. M. Ward, "Terminal Care in Malignant Disease," *Social Science and Medicine* 8 (1974): 413-420.

It is more difficult to explain the reasons why women cared for the dying, and my evidence offered no easy answers. A recent study of caregiving in the twenty-first century claims that women's principal motive for assuming the caregiving role is not love and self-sacrifice. Despite strong emotional ties between caregiver and care receiver, Karen R. Grant and others argue that caregiving relations remain structured in a coercive way, "given the absence of real choice and true alternatives in a society based on the sexual division of labour."[5] In contrast, Emily K. Abel challenges assumptions by some feminist scholars that women generally assumed the role of caregiver as a response to "oppressive ideological and material forces." Abel concludes that women often chose to care, and in some cases caregiving actually contributed to women's maturity and autonomy.[6] Of course, caring for a beloved family member in the final hours of his or her life could be a devastating and traumatic experience, but it could also be, as Abel has suggested, a "profound human experience that conferred meaning" on caregivers' lives.[7] We cannot know for sure which women chose to care for the dying and which had that role imposed on them.

Today, experts in palliative care and hospice care agree that the requirements for effective care of the dying in the home are: a strong and competent primary caregiver, additional assistance from family members and friends, and adequate palliative care from health care professionals.[8] These ingredients, or variations of them, were also important in the familial provision of care of the dying historically. The home care "team" in the early to mid-twentieth century was made up of at least several of the following team members: the patient; at least one female relative of the patient who served as primary caregiver; other family members from within or outside of the household who provided additional care; one or more physicians; one or more professional nurses, depending on availability of family resources; informal nursing care providers, including domestic help, community members or friends of the family; clergy or other religious persons, including nuns; and visitors from the community who may have provided a number of services, including material, emotional, and social. During the first half of the twentieth century, family members, friends and neighbors were sometimes joined by doctors, nurses and clergy to form a network of caregivers that looked very much like the hospice team that hospice leaders began promoting as the answer to end-of-life care in the early 1970s. In fact, this caregiving network also resembled the female support network that Judith Walzer Leavitt describes in her study of the history of birthing women and the women's survival networks in working-class London during the first quarter of the twentieth century that Ellen Ross has written about.[9]

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[5] Karen R. Grant et al., *Caring For/Caring About: Women, Home Care, and Unpaid Caregiving* (Aurora, ON: Garamond Press, 2004), 81.

[6] Emily K. Abel, *Hearts of Wisdom: American Women Caring for Kin, 1850-1940* (Cambridge and London: Harvard University Press, 2000), 4.

[7] Abel, *Hearts of Wisdom*, 172.

The history of care of the dying has a lot to offer health policy makers. Today, they advocate that care of the dying ought to be returned to the home. Evidence suggests that families stopped providing terminal care in the home during the last third of the twentieth century, but a great deal more research needs to be done in order to understand this transition from home to hospital. The present contribution brings us one step closer to that understanding.

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[8] Jana Staton, Roger Shuy, and Ira Byock, *A Few Months to Live: Different Paths to Life's End* (Washington: Georgetown University Press, 2001), 222.

[9] Ellen Ross, "Survival Networks: Women's Neighbourhood Sharing in London Before World War One," *History Workshop Journal* 15 (1983); Judith Walzer Leavitt, *Brought to Bed: Childbearing in America 1750-1950* (New York: Oxford University Press, 1986).

This dissertation is not in any way intended to promote home care as the best model for care of the dying. Health policy makers must understand the history of home care in North America before uncritically endorsing "home deaths" as a fiscally responsible alternative to death in acute care institutions. However, a discussion about "choice" is clearly on the agenda. Ultimately, dying people ought to be able to choose where they want to die. If North Americans could agree upon this major organizing principle, society could move forward to organize the support and resources required to fulfill each individual's choice and assign resources where they are needed. For example, for those people who want to die at home, more investment is needed in home care nursing programs and more physicians need to be encouraged to make home visits. Similarly, more investment is required to improve both the quality and the quantity of hospice or palliative care services available to those wishing to spend their final days in an institutional setting.

Family members should also be able to choose whether or not they want to provide terminal care. If patient and family preferences about the site of terminal care differ, the patient's wishes ought to prevail, but only in terms of site of care. If family members choose not to provide care, ideally the patient should be able to access the services of paid caregivers who could come into the home. Regardless of where they die and who cares for them, dying people are entitled to receive appropriate, compassionate care. Of course, defining "appropriate" is a tricky task. What is appropriate for one patient may be inappropriate for another. Although my mother agreed with her oncologist that further cancer treatment would be futile, some patients wish to pursue aggressive treatment until the very end. Are they wrong to do so? There are no easy answers to these complex questions.

In order to address the many and diverse problems related to care of the dying, North Americans must really begin to think and talk more about terminal care. Too often, when faced with the crisis of impending death from terminal illness, neither patients nor family are equipped with enough information to make informed and personally appropriate decisions. Although physicians ought to be the persons supplying families with information and options, more often than not they are as poorly informed as the general public about the availability of palliative care or hospice services in the community. Hence, today the hospital serves as the default site for care of the dying.

In the end, the topic of choice in health care is perhaps more clearly a social and political issue than a medical one. North American society gives lip service to the concept of "patient rights," recognizing that individuals are entitled both to receive appropriate medical care and to decide for themselves what constitutes appropriate care. Translating that principle of entitlement and choice into reality, for the dying and for their caregivers, is a crucial and urgent matter.

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